STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 000	Initial Comments The Adult Care Licensure Section and Mecklenburg County Department of Social Services conducted a follow up survey and a complaint investigation from 08/01/23 to 08/03/23. The complaint investigation was initiated by the County Department of Social Services on 07/17/23.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 1 of 5 sampled residents (Resident #1) related to notifying the physician regarding his change in condition, refusals for assistance with personal care, refusals to take medications, and refusals of food and hydration for several days. The findings are: Review of Resident #1's FL2 dated 03/26/22 revealed: -Diagnoses included neurocognitive disorder, major depressive disorder, hypertension, hyperlipidemia, history of recurrent urinary tract infections, and open angle glaucoma. -Resident #1 required level of care was a Special Care Unit (SCU). Review of Resident #1's Care Plan dated	D 273		

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D 273	Continued From page 1 05/03/23 revealed: -It was not signed by the primary care provider (PCP) -Resident #1 required assistance with dressing and bladder hygiene. -Resident #1 required full assistance with personal hygiene. -Resident #1 required reminders for bathing, as well as stand-by assistance while he was bathing. -Resident #1 required "multiple attempts for hygiene purpose" and was resistant to bathing assistance. -Resident #1 required reminders with toileting. -Resident #1 "manages regular resistance to care or assistance independently or with intervention; multiple attempts required for hygiene purposes." Review of Resident #1's SCU profile dated 04/04/23 revealed: -Resident #1 exhibited wandering behaviors "at times." -Resident #1 was verbally abusive "can use foul language when staff attempts to perform activities of daily living" (ADLs). -Resident #1 required assistance with dressing, grooming, toileting, and bathing. -Resident #1 was independent with eating and ambulation. -Resident #1 refused personal care "resident will refuse but staff encouragement." -Resident #1 refused medications. -There were no specific interventions to be used to address Resident #1's documented behaviors. Review of Resident #1's Licensed Health Professional Support review completed 05/24/23 revealed: -Resident #1 required ambulation assistive devices. -Resident #1 refused personal care and	D 273		

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medications.
-There was no documentation of interventions that should be used regarding his refusals of care and medications.

Review of Resident #1's Emergency Department (ED) Provider's notes dated 07/16/23 at 4:40pm revealed:
-The chief complaint was altered mental status.
-Emergency Medical Service (EMS) reported Resident #1 was found in his bed, disheveled with a strong odor of urine, clothing fouled with multiple fluids, fluids on the floor including soiled adult briefs.
-Staff reported a history of Resident #1 not eating or drinking and refusing medications for 2 days.
-Limited history suggested he had very little oral intake in the past several days for unclear reasons.
-Resident #1's vital signs on arrival to the ED were documented as follows; blood pressure of 94/73 (normal 120/80), heart rate of 117 (normal between 60-100 beats per minute), respirator rate of 22 (normal 12 to 18 breaths per minute), temperature of 99.2 (normal 97 to 99 degrees), and oxygen level of 85% on room air (normal 95% or greater on room air).
-Resident #1 was placed on 15 liters of oxygen via nasal cannula.
-The physical exam documented Resident #1 was frail, ill appearing with eyes open, barely responsive, strong odor of urine about his clothing, dry, tacky mucus membranes, and unknown dried emesis about his mouth.
-Resident #1's Glasgow Coma Scale (a clinical scale to reliably measure a person's level of consciousness) upon arrival to the ED was 7 (normal is 15 with a 7 indicating a comatose patient).
-Resident #1 presented to the ED with

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hypotension requiring prompt intravenous fluids (IV) resuscitation.
-Resident #1 was dehydrated and would require gradual rehydration while in the intensive care unit (ICU).
-The ED provider documented concerns about Resident #1's presentation of not being well cared for recently, and some suspicion for elder neglect.

Review of the Resident #1's hospital admitting provider's notes dated 07/16/23 revealed:
-Resident #1 was admitted to the ICU.
-The problems and plans were as follows; a diagnoses of shock suspected due to dehydration/hypokalemia although cannot exclude sepsis (occurs when chemicals released into the bloodstream to fight an infection trigger inflammation throughout the body which could cause damage/failure to multiple organ systems) hyponatremia secondary to dehydration (a dangerous loss of body fluid caused by illness, sweating or inadequate intake), and acute kidney injury (when the kidneys suddenly can't filter waste from the blood and develops over a few hours or days), shock (a critical condition brought on by the sudden drop in blood flow through the body) due to severe dehydration as evidenced by increased heart rate and decreased blood pressure, hypoxia (a critical low oxygen saturation level of less than 85% on room air), acute encephalopathy (a disease that alters the brain function or structure) and dementia, as evidenced by a report of poor intake and refusal of medications over the last few days to weeks and found in his own urine/excrement, and also considered infection, medication non-compliance, dementia and delirium, erythrocytosis (a high concentration of red blood cells in the body) as evidenced by a hemoglobin level of 16.8 which was greater than baseline presumable due to

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severe dehydration, hypernatremia (a high concentration of sodium in the blood) and dehydration as evidenced by his sodium level elevated to 164 on admission likely secondary due to severe dehydration in the setting of poor intake, thrombocytopenia (a low number of platelets in the blood), previously it was within normal limits so considered infection, acute kidney injury due to his creatinine level was 5.43 on admission presumable due to severe dehydration, lactic acidosis (is due to low oxygen profusion and shock), and depression as evidenced by report of him taking antidepressants but not receiving the medications in 2 weeks.

Review of Resident #1's local hospital's Geriatric Nurse Practitioner (GNP) consultation dated 07/16/23 revealed:
-Resident #1 was lethargic and briefly awakened to her voice.
-There was concern for elder neglect given his presentation to the ED and the need for medical management of acute hypernatremia and acute kidney injury in the setting of severe dehydration.

Review of Resident #1's local hospital's discharge summary dated 07/19/23 revealed Resident #1's cause of death was due to cardiopulmonary failure associated with shock, acute respiratory failure, and community-acquired pneumonia secondary to hypernatremia, acute renal failure, dementia, anemia, and thrombocytopenia.

Review of Resident #1's Death Certificate dated 07/19/23 revealed Resident #1's cause of death was septic shock, bacterial pneumonia, and advanced dementia.

a. Review of Resident #1's PCP orders dated 04/17/23 revealed:

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D 273	Continued From page 5 -There was an order for aspirin 81mg (used to prevent stroke and blood clots), 1 tablet by mouth daily at 9:00am. -There was an order for blood pressure checks daily at 9:00am, if blood pressure consistently equal to or higher than 140/90, resume amlodipine 5mg daily and schedule follow up with PCP. -There was an order for amlodipine 5mg (used to treat high blood pressure), administer daily if blood pressure consistently equal to or higher than 140/90, schedule follow up with PCP. -There was an order for citalopram 20mg (used to treat depression), 1 tablet by mouth every morning at 9:00am. -There was an order for donepezil 10mg (used to treat memory loss), 1 tablet by mouth at bedtime at 9:00pm. -There was an order for latanoprost 0.005% (used to treat increased pressure in the eyes), 1 drop into both eyes at bedtime at 9:00pm. -There was an order for memantine 10mg (used to treat Alzheimers disease and dementia), 1 tablet by mouth twice daily at 9:00am and 9:00pm "discontinued per mental health note". -There was an order for mirtazapine 15mg (used to treat depression), 0.5 tablet by mouth at bedtime at 9:00pm. -There was an order for pantoprazole 40mg (used to treat increased stomach acid), one tablet by mouth every day for 30 days at 9:00am. -There was an order for simbrinza 1%-0.2% (used to treat increased pressure in the eyes and glaucoma), instill 1 drop into both eyes three times daily for glaucoma at 9:00am, 3:00pm, and 9:00pm. -There was an order for tamsulosin 0.4mg (used to treat enlarged prostate), take 1 capsule by mouth at bedtime at 9:00pm. -There was an order for vitamin D3 50mcg tablet	D 273		

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(used to treat vitamin D deficiency), take 1 tablet by mouth every day for Vitamin D deficiency.
-There was an order for hydroxyzine 25mg (used to treat anxiety), take 1 capsule by mouth every 6 hours as needed for anxiety.
-The physician's orders noted amlodipine and hydroxyzine were not ordered by the resident's PCP.

Review of Resident #1's May 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for aspirin 81mg take 1 tablet by mouth every day, scheduled for 9:00am, was documented as refused on 8 of 31 occasions on 05/05/23, 05/08/23, 05/13/23, 05/14/23, 05/19/23, 05/22/23, 05/27/23, and 05/28/23.
-There was and entry for blood pressure checks check blood pressure daily, if blood pressure consistently equal or higher than 140/90 resume Amlodipine 5mg daily and schedule follow up with PCP, scheduled for 9:00am, was documented as refused on 10 of 10 occasions on 05/01/23, 05/02/23, 05/03/23, 05/04/23, 05/05/23, 05/06/23, 05/07/23, 05/08/23, 05/09/23, and 05/10/23, and discontinued on 05/10/23.
-There was an entry for citalopram 20mg take 1 tab by mouth every morning scheduled for 9:00am was documented as refused on 8 of 31 occasions on 05/05/23, 05/08/23, 05/13/23, 05/14/23, 05/19/23, 05/22/23, 05/27/23, and 05/28/23.
-There was an entry for donepezil 10mg take 1 tablet by mouth at bedtime scheduled for 9:00pm was documented as refused on 2 of 31 occasions on 05/13/23 and 05/14/23.
-There was an entry for latanoprost 0.005% drops instill 1 drop into both eyes at bedtime scheduled for 9:00pm was documented as refused on 2 of 31 occasions on 05/13/23 and 05/14/23.

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D 273	Continued From page 7 -There was an entry for mirtazapine 15mg take 0.5 tablet (7.5mg) by mouth at bedtime scheduled for 9:00pm was documented as refused on 2 of 31 occasions on 05/13/23 and 05/14/23. -There was an entry for monthly wellness vitals scheduled for 05/05/23 at 5:00pm, including temperature, pulse, blood pressure and respiration was documented as refused. -There was an entry for pantoprazole 40mg take 1 tablet by mouth every day for 30 days scheduled for 8:00am was documented as refused on 8 of 31 occasions on 05/05/23, 05/08/23, 05/13/23, 05/14/23, 05/19/23, 05/22/23, 05/27/23, and 05/28/23. -There was an entry for simbrinza 1%-0.2% instill 1 drop into both eyes three times daily for glaucoma scheduled for 9:00am, 3:00pm, and 9:00pm was documented as refused on 12 of 92 occasions on 05/05/23 at 9:00am, 05/08/23 at 9:00am, 05/13/23 at 3:00pm, 05/13/23 at 9:00pm, 05/14/23 at 9:00am, 05/14/23 at 3:00pm, 05/14/23 at 9:00pm, 05/19/23 at 9:00am, 05/22/23 at 9:00am, 05/27/23 at 9:00am, and 05/28/23 at 9:00am. - There was an entry for tamsulosin 0.4mg take 1 capsule by mouth at bedtime scheduled for 9:00pm was documented as refused on 2 of 31 occasions on 05/13/23 and 05/14/23. -There was an entry for vitamin B-12 500mcg take 2 tablets by mouth every day scheduled for 8:00am was documented as refused on 8 of 31 opportunities on 05/05/23, 05/08/23, 05/13/23, 05/14/23, 05/19/23, 05/22/23, 05/27/23, and 05/28/23. -There was an entry for vitamin D3 50mcg take 1 tablet by mouth every day scheduled for 8:00am was documented as refused on 8 of 31 occasions on 05/05/23, 05/08/23, 05/13/23, 05/14/23, 05/19/23, 05/22/23, 05/27/23, and 05/28/23. -There was an entry for amlodipine 5mg was	D 273		

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documented as discontinued on 05/31/23.
-There was an entry for hydroxyzine 25mg take 1 capsule by mouth every 6 hours as needed for anxiety there was no documentation of administration/refusals in throughout the month.
-There was no documentation Resident #1's PCP was notified.

Review of Resident #1's June 2023 eMAR revealed:
-There was an entry for Aspirin 81mg take 1 tablet by mouth every day scheduled for 9:00am was documented as refused for 10 of 30 occasions on 06/02/23, 06/25/23, 06/10/23, 06/11/23, 06/13/23, 06/16/23, 06/19/23, 06/24/23, 06/25/23, and 06/30/23.
-There was an entry for citalopram 20mg take 1 tablet by mouth every morning scheduled for 9:00am was documented as refused for 10 of 30 occasions on 06/02/23, 06/05/23, 06/10/23, 06/11/23, 06/13/23, 06/16/23, 06/19/23, 06/24/23, 06/25/23, and 06/30/23.
-There was an entry for donepezil 10mg take 1 tablet by mouth at bedtime scheduled for 9:00pm was documented as refused for 9 of 30 occasions on 06/11/23, 06/13/23, 06/14/23, 06/15/23, 06/21/23, 06/26/23, 06/27/23, 06/28/23, and 06/30/23.
-There was an entry for latanoprost 0.005% drops instill 1 drop into both eyes at bedtime scheduled for 9:00pm was documented as refused for 8 of 30 occasions on 06/11/23, 06/13/23, 06/14/23, 06/15/23, 06/21/23, 06/26/23, 06/28/23, and 06/29/23.
-There was an entry for mirtazapine 15mg take 0.5 tablet (7.5mg) by mouth at bedtime scheduled for 9:00pm was documented as refused for 9 of 30 occasions on 06/13/23, 06/14/23, 06/15/23, 06/21/23, 06/26/23, 06/27/23, 06/28/23, 06/29/23, and 06/30/23.

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D 273	Continued From page 9 -There was an entry for monthly wellness vitals, scheduled for 5:00pm on 06/04/23, including temperature, pulse, blood pressure and respiration was documented as refused. -There was an entry for pantoprazole 40mg take 1 tablet by mouth every day for 30 days scheduled for 8:00am was documented as refused for 10 of 30 occasions on 06/02/23, 06/05/23, 06/10/23, 06/11/23, 06/13/23, 06/16/23, 06/19/23, 06/24/23, 06/25/23, and 06/30/23. -There was an entry for simbrinza 1% - 0.2% instill 1 drop into both eyes three times daily for glaucoma scheduled for 9:00am, 3:00pm and 9:00pm was documented as refused for 19 of 90 occasions on 06/02/23 9:00am, at 06/05/23 at 9:00am, 06/10/23 at 9:00am, 06/11/23 at 9:00am, 06/11/23 at 3:00pm, 06/12/23 at 3:00pm, 06/13/23 at 9:00am, 06/13/23 at 9:00pm, 06/14/23 at 9:00pm, 06/15/23 at 9:00pm, 06/16/23 at 9:00am, 06/19/23 at 9:00am, 06/21/23 at 9:00pm, 06/24/23 at 9:00am, 06/25/23 at 9:00am, 06/26/23 at 9:00pm, 06/28/23 at 9:00pm, 06/29/23 at 9:00pm, 06/30/23 at 9:00am. -There was an entry for tamsulosin 0.4mg take 1 capsule by mouth at bedtime scheduled for 9:00pm was documented as refused for 9 of 30 occasions on 06/13/23, 06/14/23, 06/15/23, 06/21/23, 06/26/23, 06/27/23, 06/28/23, 06/29/23, and 06/30/23. -There was an entry for vitamin B-12 500mcg take 2 tablets by mouth every day scheduled for 8:00am was documented as refused for 10 of 30 occasions on 06/02/23, 06/05/23, 06/10/23, 06/11/23, 06/13/23, 06/16/23, 06/19/23, 06/24/23, 06/25/23, and 06/30/23. -There was an entry for vitamin D3 50mcg take 1 tablet by mouth every day scheduled for 8:00am was documented as refused for 10 of 30 occasions on 06/02/23, 06/05/23, 06/10/23,	D 273		

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06/11/23, 06/13/23, 06/16/23, 06/19/23, 06/24/23, 06/25/23, and 06/30/23.
-There was an entry for hydroxyzine 25mg was documented as discontinued on 06/02/23.
-There was no documentation Resident #1's PCP was notified.

Review of Resident #1's July 2023 eMAR from 07/01/23 to 07/16/23 revealed:
-There was an entry for aspirin 81mg take 1 tablet by mouth every day scheduled for 9:00am was documented as refused on 13 of 16 occasions on 07/01/23, 07/02/23, 07/03/23, 07/05/23, 07/06/23, 07/07/23, 07/08/23, 07/09/23, 07/12/23, 07/13/23, 07/14/23, 07/15/23, and 07/16/23.
-There was an entry for citalopram 20mg take 1 tablet by mouth every morning scheduled for 9:00am was documented as refused on 13 of 16 occasions on 07/01/23, 07/02/23, 07/03/23, 07/05/23, 07/06/23, 07/07/23, 07/08/23, 07/09/23, 07/12/23, 07/13/23, 07/14/23, 07/15/23, and 07/16/23.
-There was an entry for donepezil 10mg take 1 tablet by mouth at bedtime scheduled for 9:00pm was documented as refused on 8 of 15 occasions on 07/04/23, 07/05/23, 07/06/23, 07/11/23, 07/12/23, 07/13/23, 07/14/23, and 07/15/23.
-There was an entry for latanoprost 0.005% instill 1 drop into both eyes at bedtime scheduled for 9:00pm was documented as refused on 6 of 15 occasions on 07/06/23, 07/11/23, 07/12/23, 07/13/23, 07/14/23, and 07/15/23.
-There was an entry for mirtazapine 15mg take 0.5 tablet by mouth at bedtime scheduled for 9:00pm was documented as refused on 8 of 15 occasions on 07/04/23, 07/05/23, 07/06/23, 07/11/23, 07/12/23, 07/13/23, 07/14/23, and 07/15/23.
-There was an entry for monthly vital signs on 07/05/23 at 5:00pm, including temperature, blood

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

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pressure, pulse and respiration was documented as refused.
-There was an entry for pantoprazole 40mg take 1 tablet by mouth daily for 30 days scheduled for 8:00am was documented as refused on 13 of 16 occasions on 07/01/23, 07/02/23, 07/03/23, 07/05/23, 07/06/23, 07/07/23, 07/08/23, 07/09/23, 07/12/23, 07/13/23, 07/14/23, 07/15/23, and 07/16/23.
-There was an entry for simbrinza 1%-0.2% instill 1 drop into both eyes three times daily for glaucoma, scheduled for 9:00am, 3:00pm, and 9:00pm was documented as refused on 20 of 45 occasions on 07/01/23 at 9:00am, 07/02/23 at 9:00am, 07/03/23 at 9:00am, 07/05/23 at 9:00am, 07/06/23 at 9:00am, 07/06/23 at 9:00pm, 07/07/23 at 9:00am, 07/08/23 at 9:00am, 07/08/23 at 3:00pm, 07/09/23 at 9:00am, 07/11/23 at 9:00pm, 07/12/23 at 9:00am, 07/12/23 at 9:00pm, 07/13/23 at 9:00am, 07/13/23 at 9:00pm, 07/14/23 at 9:00am, 07/14/23 at 9:00pm, 07/15/23 at 9:00am, 07/15/23 at 9:00pm, and 07/16/23 at 9:00am.
-There was an entry for tamsulosin 0.4mg take 1 capsule by mouth daily at bedtime scheduled for 9:00pm was documented as refused on 9 of 15 occasions on 07/04/23, 07/05/23, 07/06/23, 07/11/23, 07/12/23, 07/13/23, 07/14/23, and 07/15/23.
-There was an entry for vitamin B-12, 500mg take 2 tablets by mouth every day, scheduled for 8:00am was documented as refused on 13 of 16 occasions on 07/01/23, 07/02/23, 07/03/23, 07/05/23, 07/06/23, 07/07/23, 07/08/23, 07/09/23, 07/12/23, 07/13/23, 07/14/23, 07/15/23, and 07/16/23.
-There was an entry for vitamin D3, 50mcg take one tablet by mouth every day, scheduled for 8:00am was documented as refused on 13 of 16 occasions on 07/01/23, 07/02/23, 07/03/23,

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D 273	Continued From page 12 07/05/23, 07/06/23, 07/07/23, 07/09/23, 07/09/23, 07/12/23, 07/13/23, 07/14/23, 07/15/23, and 07/16/23. -There was no documentation Resident #1's PCP was notified. Review of Resident #1's May 2023 progress notes revealed: -On 05/05/23 staff documented Resident #1 refused all morning medications; the medication aide (MA) made 3 attempts and the resident refused all the time. There was no documentation regarding follow-up with Resident #1's PCP. -On 05/08/23 staff documented Resident #1 refused morning medications and that the MA made 3 attempts. Resident #1 told staff he took his medications from the government. -On 05/13/23 staff documented Resident #1 refused all medications that day and that multiple attempts from multiple staff members were unsuccessful. -On 05/14/23 staff documented Resident #1 refused all medications that day and that multiple attempts from multiple staff were unsuccessful. -On 05/16/23 at 2:08pm, staff documented Resident #1 was continuing to refuse medications. Resident #1's RP was aware of the situation and PCP was notified via fax and no new orders were received. Staff explained to Resident #1 why it was important to take his medications and "he has the capacity to fully understand the information and still refuses. We will continue to urge patient to comply and encourage him daily." -On 05/16/23 at 4:41pm staff documented Resident #1 continued to refuse medications. -On 05/16/23 at 4:41pm staff attempted to reach Resident #1's responsible party (RP) and left a voice message after staff called Resident #1's PCP office to inform him of Resident #1's refusals	D 273		

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and was informed the PCP was out of the office until 05/30/23 and there was no other physician answering his calls in his absence.
-On 05/16/23 staff reached out to the RP to inquire if there was a secondary physician, they should reach out to regarding medication refusals.
-On 05/17/23 staff documented a physician's order was received to discontinue blood pressure checks in reference to multiple refusals.
-On 05/19/23, Resident refused to take medications. MA attempted 3 times to administer medications.
-On 05/27/23, Resident refused all morning medications. MA attempted 3 times to administer medications.
-On 05/28/23, Resident #1 refused to take morning medications. MA attempted 3 times to administer medications.

Telephone interview with a representative from Resident #1's PCP office on 08/03/23 at 10:45am revealed Resident #1's PCP was out of the office but there was another physician who was covering and would be available to discuss Resident #1's care.

Review of Resident #1's June 2023 Progress Notes revealed:
-On 06/02/23, Resident #1 refused to take morning medications. MA attempted 4 times to administer medications.
-On 06/05/23, Resident #1 refused all morning medications. MA attempted 3 times to administer medications.
-On 06/10/23, Resident #1 refused all morning medications. MA attempted 3 times to administer medications.
-On 06/11/23, Resident #1 refused morning medications. MA attempted 3 times to administer

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medications and resident told her the "government gave him his meds."
-On 06/13/23, Resident #1 refused all his morning medications.
-On 06/26/23, Resident #1 refused his bedtime medications.
-On 06/27/23, Resident #1 took all eye drop medications, but refused all oral medications. MA attempted multiple times but Resident #1 refused each time.
-On 06/28/23, Resident #1 refused medications. MA attempted 3 times to administer medications.
-On 06/30/23, Resident #1 told the MA that "Tiger Woods came in and gave him his morning medications." The MA explained to Resident #1 that he had more medications he needed to take, but he refused, on multiple attempts, his morning medications.
-There was no documentation the PCP or RP were notified of the medication refusals.

Review of Resident #1's July 2023 Progress Notes revealed:
-On 07/01/23, Resident #1 refused all morning medications after multiple attempts.
-On 07/02/23, Resident #1 refused all medications this shift on multiple attempts.
-On 07/03/23, Resident #1 refused morning medication. MA attempted 3 times to administer medications.
-On 07/04/23, Resident #1 received all eye drops but refused all pills. MA attempted 3 times to administer medications.
-On 07/05/23 9:38am, Resident #1 refused all morning medications as well as breakfast, and stated he had already taken his medications.
-On 07/05/23 9:19pm, Resident #1 refused all pills and took his eye drops. MA attempted multiple times to administer medications.
-On 07/07/23 2:08pm, Resident #1 refused all

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medications on this shift.
-On 07/08/23, Resident #1 refused all morning medications. MA attempted multiple times to administer medications.
-On 07/09/23, Resident #1 refused all morning medications. MA attempted multiple times to administer medications.
-On 07/11/23, Resident #1 refused all nighttime medications. MA attempted 3 times to administer medications.
-On 07/14/23, Resident #1 refused all medications. MA attempted multiple times to administer medications.
-On 07/15/23, Resident #1 refused dinner and evening meds "continuously after asking."
-On 07/16/23, Resident #1 refused all medications. Several attempts were made to administer medications.
-There was no documentation the PCP or RP were notified of the medication refusals.

Interview with a MA on 07/17/23 and 08/02/23 at 3:45pm revealed:
-Resident #1 had been refusing most medications for a few months, and prior to that, refused intermittently for months.
-Resident #1 would almost always refused all his pills.
-When Resident #1 refused his medications, she always made at least 3 attempts to get him to take his medications before she documented the refusal, and she would notify the Special Care Unit Coordinator (SCC) and the HWD.
-She had spoken on multiple occasions with the SCC and the HWD regarding his refusals of medications but all they would say was "Ok, we will have to come up with something" or they said they would contact the RP or Resident #1's physician about his refusals, but she never received any direction on what should be done

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Resident #1 refused his medications.
-She attempted to come up with a plan on her own to get Resident #1 to take his medications because she knew it was important that Resident #1 received his medications as ordered by the physician.
-She attempted to administer his medications by crushing them in applesauce and pudding, which worked once or twice until she suspected Resident #1 could taste the medications, and then he would never accept an open cup of pudding or applesauce from her again.
-If she knew no one was following up with the physician regarding Resident #1's refusals of medications, she would have called the physician herself, but the process was supposed to be that the MA informed the HWD of any medication refusals, and the HWD was supposed to follow up with the physician.

Interview with the HWD on 07/17/23 at 11:30am revealed:
-Resident #1 frequently refused to take his medications.
-Sometimes staff were able to get Resident #1 to take his medications by telling him they were vitamins, but this eventually stopped working.
-She had reached out to the physician in the past regarding his medication refusals but did not specify a date.
-Resident #1 had refused daily blood pressure checks and she had communicated with the physician about this a few months ago and gotten an order dated 05/12/22 to discontinue the blood pressure checks due to refusals.

Interview with a pharmacist at the facility's backup pharmacy on 08/03/23 at 10:39am revealed:
-There was a profile with medications from the PCP orders dated 04/17/23 on file for Resident

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D 273	Continued From page 17 #1. -There was an order for aspirin 81mg, 1 tablet by mouth daily at 9:00am, could be used for prevention of stroke and if not being administered as ordered, it could result in and increased chances of blood clots. -There was an order for citalopram 20mg, 1 tablet by mouth every morning at 9:00am, used as an antidepressant and if not be administered as ordered, there could be the risk of increased depression. -There was an order for donepezil 10mg, 1 tablet by mouth at bedtime at 9:00pm, used for memory issues and if not administered as ordered, there could be an increase of worsening symptoms of memory issues. -There was an order for latanoprost 0.005%, 1 drop into both eyes at bedtime at 9:00pm, a medication used to treat pressure in the eyes and if not being administered as ordered then there could be increased pressures of the eye to increase and could cause vision loss or blindness. -There was an order for memantine 10mg, 1 tablet by mouth twice daily at 9:00am and 9:00pm, a medication used to treat Alzheimer disease and if not administered as ordered there could be worsening symptoms of Alzheimer disease and dementia. -There was an order for mirtazapine 15mg, 0.5 tablet by mouth at bedtime at 9:00pm, a medication used to treat depression and if not administered as ordered could increase the symptoms of depression. -There was an order for pantoprazole 40mg, one tablet by mouth every day for 30 days at 9:00am, a medication used for stomach acid build up and if not administered as ordered then there could be an increase of stomach acid. -There was an order for simbrinza 1%-2%, instill	D 273		

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D 273	Continued From page 18 1 drop into both eyes three times daily for glaucoma at 9:00am, 3:00pm, and 9:00pm, a medication used to treat the pressures in the eyes and if not administered as ordered then it could result in the pressures of the eye to increase and could cause vision loss or blindness. -There was an order for tamsulosin 0.4mg, take 1 capsule by mouth at bedtime at 9:00pm is a medication used to treat enlarged prostrate and if not administered as ordered could increase urinary retention. -There was an order for vitamin D3 50mcg tablet, take 1 tablet by mouth every day for vitamin D deficiency and if not administered as ordered it could cause increased fatigue. -There was an order for amlodipine 5mg, administer daily if blood pressure consistently equal or higher than 140/90 and if not administered as ordered it could cause an increase of the blood pressure and could lead to a heart attack or stroke. -There was an order for hydroxyzine 25mg, take 1 capsule by mouth every 6 hours as needed for anxiety and if not administered as ordered it could lead to increased symptoms of anxiety. Interview with a PCA on 07/27/23 at 10:45am revealed: -When residents refused medications, the MA was supposed to make at least 3 attempts to administer the medications. -Resident #1 always refused his medications. -When Resident #1 refused his medications, the MA would document the refusal on the eMAR and would report the refusal to the Health and Wellness Director (HWD). -She was never directed by the MAs on what should be done when Resident #1 refused to take his medications.	D 273		

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D 273	Continued From page 19 Interview with the facility's Licensed Practical Nurse (LPN) on 07/17/23 at 2:05pm revealed: -Resident #1 consistently refused all medications when she attempted to administer them in the last 3 weeks. -Prior to the last few weeks, she was usually able to get Resident #1 to take his medications. Telephone interview with the former SCC on 08/03/23 at 12:16pm revealed: -Resident #1 had a long history of refusing medications. -When residents had a pattern of medication refusals, staff were supposed to inform the HWD, so that she could follow up with their physician. -She did not reach out to Resident #1's physician regarding his medication refusals, because this was the responsibility of the HWD. Telephone Interview with Resident #1's family member on 08/03/23 at 10:55am revealed: -She visited the facility once or twice a month to transport Resident #1 to his doctor appointments. -Staff had never discussed with her Resident #1's refusals of medications. -She had observed that staff regularly documented he refused medications on his MARs. -She recalled the physician was concerned about the documented refusals of medications and attempted to have a conversation with Resident #1 regarding the importance of taking his medications at a visit a few months ago. -She was not sure if Resident #1 would remember the conversation with the physician once he was back at the facility when it was time to take his medications because he had dementia. -She never met the SCC or the HWD during her	D 273		

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visits to the facility and dealt mostly with the PCAs who helped get Resident #1 ready for his appointments.

Telephone interview with Resident #1's RP on 08/03/23 at 8:27am revealed:
-He lived several states away and had scheduled FaceTime visits with Resident #1 every Friday afternoon.
-The last communication he received from the facility regarding Resident #1's medication refusals was over a year ago.
-He had expressed his concerns regarding Resident #1's care on several occasions but he "had no idea" Resident #1 had been refusing medications regularly over the past several months.
-He assumed the facility had addressed the medication refusals when they last spoke about them a year ago and the issue was resolved.
-He had only spoken with the SCC when staff did not set up the weekly FaceTime calls, and she had never mentioned any concerns with medication administration for Resident #1.
-He did not recall speaking with the HWD regarding Resident #1's medication refusals.

Telephone interview with the Geriatric Nurse Practitioner (GNP) on 08/03/23 10:23am revealed:
-She was asked to see Resident #1 by the ED Physician due to concerns for neglect by the facility in which he resided since 02/01/18.
-She reviewed Resident #1's eMARs that were sent with him to the hospital and was very concerned to see he had been refusing medications regularly the entire month of July 2023.
-She attempted to call the facility on five occasions to obtain more information regarding

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his medication refusals but was unable to get an answer at the facility or leave a voicemail.
-Resident #1 should have received medical attention sooner due to his medication refusals and decline in his overall condition.
-If Resident #1 had received medical care sooner, he may have had a better prognosis.

Interview with the Administrator-In-Training (AIT) on 08/03/23 at 3:45pm revealed:
-The HWD was responsible for reviewing eMARs and progress notes daily and identifying any patterns of refusal of medication administration.
-The HWD was responsible for following up with resident's physicians regarding medication refusals.
-If a resident refused a medication more than once consecutively, the facility should have notified the physician and the residents RP.
-His expectation was that the HWD document all communications or attempts at communication with resident's physicians and RP.
-The HWD did not document phone calls and attempts of communication with Resident #1's physician regarding medication refusals.
-The HWD had faxed some communication forms to Resident #1's physician, but the facility did not always receive a response.
-When no response was received, it was the HWD's responsibility to follow-up as needed to get direction from the physician on what to do regarding medication refusals.
-His expectation of staff was that they would notify the HWD and the SCC regarding any concerns during stand-up each shift, including medication refusals, and that each level of management, all the way to the regional staff, would be informed of any concerns that were an ongoing issue until they were resolved.
-He and the SCC and the HWD had calls with

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regional support regarding Resident #1's refusals of personal care, but the calls did not focus on his medication refusals.
-He was aware that Resident #1 had a history of medication refusals, but he was not aware of how frequent the refusals had been recently.

Attempted telephone interview with Resident #1's PCP on 08/02/23 at 3:37pm and 4:02pm and on 08/03/23 at 10:45am and 3:37pm were unsuccessful.

Attempted telephone interview with the HWD on 08/03/23 at 3:26pm was unsuccessful.

b. Review of Resident #1's FL2 dated 03/26/22 revealed:
-Resident #1 was intermittently disoriented and had wandering behaviors.
-Resident #1 was ambulatory, incontinent of bladder, and continent of bowel.
-Resident #1 required assistance with bathing and dressing.

Review of Resident #1's Recorded Care Report revealed:
-Resident #1 received showers on 05/07/23, 05/10/23, 05/17/23, 05/21/23, 05/24/23, 05/28/23, 05/31/23, 06/04/23, 06/07/23, 06/14/23, 06/18/23, 06/21/23, 06/28/23, 07/02/23, 07/05/23, and 07/12/23.
-Resident #1 refused showers on 06/25/23 and 07/09/23.

Review of Bath/Shower Skin Check forms revealed:
-On 05/04/23, Resident #1 refused his shower after several attempts of encouragement from staff.
-On 05/20/23, Resident #1 refused his shower,

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

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and 3 attempts were made.
-On 05/23/23, Resident #1 refused his shower after several attempts.
-There was no documentation provided for June 2023, July 2023 or August 2023.

Review of Resident #1's Record Care Shower Reports for May 2023 through August 2023 revealed Resident #1 refused showers on 06/05/23 and 07/09/23.

Review of Resident #1's Progress Notes revealed:
-On 05/16/23 at 2:08pm, the SCC documented Resident #1 was continuing to refuse care. Resident #1's RP was aware of the situation, the PCP was notified via fax and no new orders were received.
-On 05/16/23 at 4:41pm the SCC documented Resident #1 continued to refuse care and staff attempted to reach Resident #1's RP and left a voice message. Staff called Resident #1's PCP office to inform him of Resident #1's refusals and was informed the PCP was out of the office until 05/30/23 and there was no other physician answering his calls in his absence. Staff reached out to the RP to inquire if there was a secondary physician, they should reach out to regarding personal care.
-On 05/30/23 at 5:24am, a MA documented Resident #1 refused all personal care.
-On 05/31/23 at 5:12am, a MA documented Resident #1 refused all morning care.
-On 06/01/23 at 5:27am, staff documented Resident #1 refused all morning care.
-On 06/02/23 at 5:21am, staff documented Resident #1 refused all care during the shift.
-On 06/03/23 at 5:23am, a MA documented Resident #1 refused all morning care.
-On 06/04/23 at 5:42am, Resident #1 refused all

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care during the shift.
-On 06/08/23 at 5:31am, a MA documented Resident #1 refused all morning care.
-On 06/09/23 at 5:18am, staff documented Resident #1 refused all personal care during the shift.
-On 06/11/23 at 5:20am, staff documented Resident #1 refused all care.
-On 06/14/23 at 5:31am, a MA documented Resident #1 refused all morning care.
-On 06/15/23 at 5:41am, staff documented Resident #1 refused care.
-On 06/16/23 at 5:24am, a MA documented Resident #1 refused all morning care.
-On 06/19/23 at 5:36am, staff documented Resident #1 refused all care during the shift.
-On 06/19/23 at 9:53pm, staff documented Resident #1 refused care from staff.
-On 06/20/23 at 5:21am, a MA documented Resident #1 refused all morning care.
-On 06/21/23 at 5:48am, a MA documented Resident #1 refused all morning care.
-On 06/22/23 at 5:40am, staff documented Resident #1 refused all care.
-On 06/23/23 at 5:36am, a MA documented Resident #1 refused all morning care.
-On 06/24/23 at 5:30am, staff documented Resident #1 refused all care during the shift.
-On 06/25/23 at 5:05am, a MA documented Resident #1 refused all morning care.
-On 06/26/23 at 5:05am, a MA documented Resident #1 refused all morning care.
-On 06/28/23 at 5:24am, staff documented Resident #1 refused all care during the shift.
-On 06/29/23 at 5:05am, a MA documented Resident #1 refused all morning care.
-On 06/30/23 at 5:13am, a MA documented Resident #1 refused all morning care.
-On 07/01/23 at 1:22pm, an LPN documented Resident #1 refused all morning care after

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D 273	Continued From page 25 multiple attempts. -On 07/02/23 at 5:56am, a MA documented Resident #1 refused all morning care. -On 07/03/23 at 5:46am, a MA documented Resident #1 refused all morning care. -On 07/05/23 at 5:23am, a MA documented Resident #1 refused all morning care. -On 07/07/23 at 2:18pm, an LPN documented Resident #1 refused all care. -On 07/10/23 at 11:00am, the SCD documented Resident #1 refused care. -On 07/11/23 at 5:18am, a MA documented Resident #1 refused all morning care. -On 07/11/23 at 3:57pm, the HWD documented Resident #1 refused care. Staff documented "it sometimes takes up to four caregivers to assist with bathing as Resident #1 can become very aggressive." Staff documented the RP, and the physician were notified on "several different occasions." -On 07/12/23 at 5:14am, a MA documented Resident #1 refused all morning care. -On 07/13/23 at 5:21am, a MA documented Resident #1 refused all morning care. -On 07/13/23 at 2:56pm, the SCD documented Resident #1 refused all morning care, and she will continue to follow-up a needed. -On 07/14/23 at 10:54am, a MA documented Resident #1 refused all morning care. -On 07/14/23 at 4:19pm, the SCD documented at 3:00pm, she, the AIT, the Regional Director of Special Care and Programming had a discussion on Resident #1's refusals to care. Resident #1 continued to refuse care with different interventions were put in place. The Leadership team suggested another different approach to try to get Resident #1 to comply with care, and will follow-up as needed. -On 07/15/23 at 12:53pm, an LPN documented Resident #1 refused all care.	D 273		

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07/16/23 at 5:34am, staff documented Resident #1 refused all care during the shift.
-On 07/16/23 at 12:16pm, an LPN documented Resident #1 refused care.

Telephone interview with a representative from Resident #1's PCP office on 08/03/23 at 10:45am revealed Resident #1's PCP was out of the office but there was another physician who was covering and would be available to discuss Resident #1's care.

Interview with the Resident Care Director (RCD) on 07/17/23 at 11:30am revealed:
-On Friday 07/14/23, Resident #1's RP, who lives in another state, Facetime him for their usual weekly call.
-She and the Executive Director spoke last week regarding getting hospice involved due to Resident #1's refusals of care and decline.
-She had left several voicemail's for the Resident #1's RP over the past few weeks regarding his refusal of personal care.
-The SCC had told her that she had also emailed Resident #1's RP regarding his refusals.

Review of Resident #1's record revealed:
-The facility was not able to produce any emails from the SCC to Resident #1's RP regarding his refusals of care.
-There was no documentation since 05/16/23 of attempts to reach either Resident #1's physician or RP regarding his refusals of care by the HWD.

Telephone interview with former SCC on 08/03/23 at 12:16pm revealed:
-She was responsible for overseeing the non-clinical care tasks for residents in the SCU.
-Resident #1 refused showers and assistance with personal care frequently.

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-She recalled speaking with Resident #1's RP in May 2023 or June 2023 during his weekly face time call with Resident #1, regarding ongoing refusals of personal care.
-She had tried changing Resident #1's shower time, but this did not seem to impact his refusals.
-Residents who required incontinence care were supposed to be checked every 2 hours and assistance with wiping and changing briefs should have been provided at that time.
-Off and on for months Resident #1 would refuse assistance with incontinence care.
-When he refused, staff would sometimes lay out clean clothing for him to change himself into, as he would refuse assistance in changing clothes as well.
-She recalled once, he had fecal matter on him after a bowel movement, and he refused to let her assist him in cleaning himself up, so she sat wet wipes out and he cleaned himself as good as he could.
-Resident #1 was not able to thoroughly clean himself with the wipes and there was still fecal matter on his skin after he was finished. She was not able to further assist him in cleaning up.
-Resident #1 eventually stopped coming out of his room for meals.
-She never contacted the physician regarding Resident #1's refusals of personal care.
-Additional calls were held with the facility's regional support staff in May 2023, and on the Friday (07/14/23) prior to resident going to the hospital on 07/16/23, she had another call with regional support staff to discuss his ongoing refusals of care. No other concerns regarding Resident #1's care were discussed during the call.
-She had a discussion in April 2023 with the HWD regarding Resident #1's refusals with care, so everyone was aware, and she did not say

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anything else.
-The HWD is responsible for updating care plans and for communicating with physicians.
-Initially, a regional support staff member brought to her attention that Resident #1 had a pattern of refusing personal care assistance and a call was held with the regional support staff to discuss the barriers to personal care.

Interview with MA on 07/17/23 at 1:45pm and 08/02/23 at 3:45pm revealed:
-She usually worked in the SCU from 6:00am to 2:00pm.
-Over the past 2 months, Resident #1 had refused personal care assistance on a daily basis.
-If staff were not successful in completing a shower for him on the scheduled shift, the next shift would try.
-Resident #1 was resistant to assistance with incontinence care and would often tell staff to let him do it himself.
-Resident #1 would often put on the same dirty clothing after he showered.
-It was difficult for staff to get the dirty clothes from his room because if he saw them trying to take the dirty clothes, he would become combative.
-She reported the refusals to the SCC but she did not document it.

Interview with a personal care aide PCA on 07/27/23 at 11:45am revealed:
-Resident #1 was often on her assignment.
-Resident #1 did not like to take showers and body foul body odor because of not taking showers.
-When he came to the dining room, other residents complained about the odor.
-She was directed the SCC to take Resident #1

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his meals in his room because other residents had complained about the smell.
-Resident #1 often refused toileting and incontinence assistance because he "wanted to be independent."
-Resident #1 would attempt to change his own brief in the bathroom sometimes but did not clean himself sufficiently.
-When staff were not successful in giving a resident a shower, they were supposed to pass the shower on to the next shift to attempt.
-She had not been directed on any specific interventions to use when Resident #1 became combative when she attempted personal care and shower assistance.

Interview with a second PCA on 07/27/23 at 11:15am revealed:
-Resident #1 had been combative and would refuse showers and all personal care since she began working in the facility in August 2022.
-She and other staff tried to encourage him to allow them to assist him with personal care, but he would tell them to get out of the room.
-Staff tried to tell him his family said they wanted him to take a shower, but this would make him angry.
-Resident #1 would kick, spit, bite, and curse at staff when they attempted to assist him.
-When Resident would become combative with her attempts to aid with personal care, she would report this to the MA and the SCC.
-She was not sure what happened after Resident #1 refused care.
-Resident #1 would attempt to change himself but could not clean himself very well.
-Resident #1 would hide soiled briefs under his bed and in other places in his room and bathroom.
-Resident #1 would allow staff to clean up his

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room and they would throw the soiled briefs they found away.
-Resident #1's bed often became wet with urine even though he had a mattress cover on it.
-She was never successful in assisting Resident #1 with a shower.
-She was aware that second shift was successful on one occasion with assisting him with a shower.
-When a resident refused showers, the assigned shift was supposed to tell the next shift so they could attempt to assist the resident again.
-She had never been told any specific interventions to use to get Resident #1 to take a shower or allow her to assist with personal care.

Interview with a third PCA on 08/02/23 at 2:10pm revealed:
-Residents were assigned specific days and shifts for showers and staff also provided showers for residents "as needed" if not their scheduled day.
-He started working in the facility in June and staff told him that Resident #1 had always refused showers and personal care.
-Resident #1 was always on his assignment list.
-Resident #1 was very combative when staff attempted to provide personal care to him.
-Resident #1 would argue and curse if you told him, it was his "shower day."
-He was never successful in getting Resident #1 to take a shower.
-He recalled once when he attempted to take Resident #1's pants off because they were soiled, Resident #1 grabbed his wrist very hard, so he stopped trying to take his pants off.
-He could not recall if other staff were successful in getting the soiled pants off on that occasion.
-When residents refused showers, staff reported the refusals to the MA after multiple attempts.
-Other staff members told him that Resident #1's family was aware he refused showers and

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personal care regularly.
-He had not been directed by management on how to handle Resident #1's refusals other than to make 3 attempts and to notify the MA of refusals.

Interview with fourth PCA on 08/02/23 at 3:10pm revealed:
-When residents refused showers, the PCA was supposed to notify the medication aide (MA) or Licensed Practical Nurse (LPN) to witness the refusal.
-Staff would make multiple attempts to provide residents who refused with a shower and/or incontinence care.
-If staff were not able to get a resident to take a shower on their scheduled shift, the next shift would attempt to shower the resident.
-Residents in the SCU received showers at least twice a week and had assigned shower days and times.
-When she attempted to shower Resident #1, she always had another staff member with her.
-She could almost always get him to take a shower.
-Resident #1 would allow her to assist him with incontinence care when he was in bed, but he often did not want to get out of bed.
-The last few months Resident #1 resided in the facility he did not come out of his room for meals.

Telephone interview with Geriatric Nurse Practitioner on 08/03/23 10:23am revealed:
-She was asked to see Resident #1 by the emergency department (ED) physician due to concerns for neglect by the facility in which he resided.
-She observed Resident #1 to have a very dry mouth and was very unclean in his appearance and had strong body odor.

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-EMS had reported to her that Resident #1 had a "very foul odor" and there were on the floor of his room at the facility.
-She attempted to call the facility 5 times to obtain more information, but no one answered the phone at the facility and she was unable to leave a voicemail.
-Resident #1 was unresponsive and could only look in her direction.
-He was not able to verbally respond to any questions.

Telephone interview with Resident #1's family member on 08/03/23 at 10:55am revealed:
-She visited Resident #1 at the facility a few times per month and transported him to his medical appointments.
-She recalled bringing wet wipes to the facility on at least one occasion because they had called her and said he had run out of wipes.
-Resident #1 often smelled strongly of urine when she would go to pick him up for his appointments.
-She had found him on multiple occasions to be laying in the bed in urine-soaked clothing when she arrived.
-Staff often reported they had attempted him to change clothes but were not successful.
-Often she would arrive and find him in soiled clothing.
-She was not able to get him to agree to "wash up" but he would sometimes agree to change his clothes, and other times, he would say he had "just changed clothes" and would refuse to do so again.
-She had never spoke with the SCC, only the PCAs who provided care to Resident #1.

Telephone interview with Resident #1's RP on 08/03/23 at 8:27am revealed:
-Resident #1 had always had poor hygiene, even

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prior to his admission to the facility in 2018.
-He had a scheduled Facetime call with Resident #1 every Friday afternoon.
-He had observed during his Facetime calls that Resident #1 sometimes looked disheveled, and his clothing did not always look fresh.
-The last time he received a call from the facility regarding Resident #1's hygiene was when the prior AIT was in the building and called him herself, prior to March 2023.
-The last Care Plan meeting he had been included on was in May 2022, when Resident #1 moved to the SCU.
-It had been at least two years since any staff member who was providing "hands on" care to Resident #1.
-Staff called him and expressed they were having a difficult time getting him to shower and asked him if he could speak to him to try to get him to shower.
-He had spoken with the HWD and former AIT on a few occasions regarding Resident #1's refusals of care and they would ask him what they should do about his refusals.
-He received a voicemail on 11/16/22 from the SCC stating Resident #1 "continues to refuse showers."
-The only time he recalled speaking with the SCC directly was when he was not able to reach Resident #1 for his weekly scheduled Facetime call, so that she could set up the call.
-He lived several states away from the facility and there was little he could do from that distance to get Resident #1 to comply with showers and personal care assistance.
-Resident #1 had always been a very social person and in the past was always excited to tell him about the activities that he had attended recently and what was coming up, and about what he'd had for lunch or dinner when he spoke

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with him on the phone or on their Facetime calls.
-He felt that since Resident #1's hygiene was so poor, staff did not encourage him to come out of his room for meals and activities, which contributed to his decline.
-He had reached out to the facility on several occasions regarding his concerns about Resident #1's care but never got clear answers on how they were going to address his care needs.
-The current AIT had only reached out to him regarding financial matters related to Resident #1's stay at the facility and they had never discussed refusals of care.
-There was no care team meeting since 2022 and the staff did not ask him about appointments with Resident #1's PCP.

Interview with AIT on 07/17/23 3:15pm and 08/03/23 at 3:45pm revealed:
-Resident #1 had a long history of refusing assistance with showers and incontinence care from all staff.
-He, the HWD, and the SCC had several calls with their regional corporate support staff regarding his refusals of care and how they may be able to best meet his needs.
-The past few months, his refusals of care have been more frequent.
-The HWD reported to him that she left a message in the last few weeks about his personal hygiene and refusals of care.
-The SCC reported that she had emailed Resident #1's RP on several occasions regarding his refusals of care.
-It sometimes took four staff to get Resident #1 up from bed.
-When residents refused care, the assigned staff member was to make multiple attempts and inform the MA and SCC so they could also attempt.

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-If refusals continued, the MA and SCU Director should inform the HWD and the AIT so that they could work with the regional support staff to attempt to meet the resident's needs.
-They had tried moving Resident #1's showers to other shifts to see if he would be more compliant at different times of day and had tried different staff members, both male and female, and they had even brought him over to the spa room on the assisted living side of the facility to see if a different environment would make a difference in his compliance with showers.
-He assumed the PCP was notified and he had no knowledge the PCP wasn't notified.

Attempted telephone interview with Resident #1's PCP on 08/02/23 at 3:37pm and 4:02pm and 08/03/23 at 10:45pm and 3:37pm were unsuccessful.

c. Review of the facility's Vital Sign Summary Report revealed:
-On 01/05/23, Resident #1 weighed 159.2 lbs.
-On 02/01/23, Resident #1 weighed 162.4 lbs.

Review of Physician's visit documentation dated 04/17/23, revealed Resident #1 weighted 147.7 lbs.

Review of hospital ED physician's documentation dated 07/16/23, Resident #1 weighed 143.3 lbs.

Review of Resident #1's May 2023 facility progress notes revealed there were no documented refusals for food in May 2023.

Review of Resident #1's June 2023 facility progress notes revealed there were no documented refusals for food in June 2023.

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Review of Resident #1's July 2023 facility progress notes revealed:
-On 07/05/23 at 9:38am, a MA documented Resident #1 refused breakfast.
-On 07/07/23 at 2:18pm, an LPN documented Resident #1 refused breakfast.
-On 07/13/23 at 2:56pm, the SCC documented Resident #1 refused breakfast and lunch.
-On 07/15/23 at 8:57pm, an LPN documented Resident #1 refused supper.
-On 07/16/23 at 12:16pm, an LPN documented Resident #1 refused breakfast and ate 10% of lunch
-On 07/11/23 at 3:57pm, the HWD documented she was notified Resident #1 was refusing meals, which was new for Resident #1, the PCP, POA were notified on different occasions and there would be a meeting today to plan different interventions.
-There was no documentation of a care meeting.
Interview with Occupational and Physical Therapy on 08/03/23 at 11:50am revealed:
-Resident #1 received occupational therapy from 04/18/22 - 10/18/22 and again from 01/02/23 - 03/30/23.
-Resident #1 received physical therapy from 04/21/22 - 05/24/22 and 12/07/22 - 12/30/22.
-He recalled seeing Resident #1 out of his room about a month ago and observed that he appeared to have lost a good bit of weight.
-He inquired with staff to find out what was going on with Resident #1 and staff reported to him that he wasn't eating.
-He was not sure if staff had followed up with the physician and Resident #1 was not on his caseload at that time, so he did not follow-up after the encounter.
-If residents in the facility had a change in appetite, he expected staff to inform the HWD, who would reach out to the physician, and notify

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him of changes related to nutrition so that they could try to implement interventions such as meal supplements.

Interview with a medication aide (MA) on 07/17/23 at 1:45 and 08/02/23 at 3:45pm revealed:
-She worked in the facility since December 2022.
-When she started working in the facility, Resident #1 always had dry cereal, a banana and juice for breakfast and would usually eat lunch well.
-Beginning in March 2023 or April 2023, Resident #1 stopped coming out of his room for meals.
-Near the end of June 2023, she observed the most drastic decline in Resident #1, when he began drinking and eating very little; often his plate was "barely touched."
-She would inform the HWD how much of his meals Resident #1 ate and that he was not eating, and she was directed by the HWD not to document this information in his progress notes.
-She had also informed the SCC in June 2023 that Resident #1 was not eating and that something had to be done.
-The SCC stated she would call his family and the HWD said she would call the doctor.
-No interventions were ever put into place to address his decreased appetite.
-While there were no recent weights documented for Resident #1, it was obvious he had lost weight by the way Resident #1's face was sunken in and his skin was looser.
-Resident #1's weight loss was really concerning and she told the PCAs they had to come up with a strategy to get some nourishment in Resident #1.
-Although Resident #1 did not have an order for Ensure, the facility had Ensure on hand, so she attempted to give him an Ensure to drink, which

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he refused, stating he was lactose intolerant.
-She had reported her concerns to the SCC and the HWD and they would say "come up with something" but never came back with a strategy or plan on how to address Resident #1's decrease appetite and weight loss.
-She assumed the SCC and the HWD were communicating with Resident #1 physician and responsible party (RP) regarding his decreased appetite and weight loss.
-Resident #1 also stopped coming out of his room for meals around the beginning of June 2023.
-She had informed the SCC and the HWD on several occasions of the decline she was observing for Resident #1 related to his medication refusals, refusals of care, refusals of food, and weight loss, and was told each time, by them that they would "come up with something" or that they were going to call the physician or Resident #1's RP, but nothing different was every implemented to address the concerns related to his decline.
-Resident #1 continued to decline over the last week prior to him going to the hospital on 07/16/23.
-The last few days, she would beg him to drink a little orange juice, and he was agreeing and say "just sit it over there" but he would never drink any of it, or even sit up in bed.
-MAs had been directed they were not to call residents' physicians and that this was the responsibility of the HWD.

Interview with a PCA on 07/27/23 at 11:15am revealed:
-She worked on 1st shift, so she was usually at the facility to observe Resident #1's intake for breakfast and lunch.
-In early April 2023, Resident #1 was still coming out of his room for all his meals.

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D 273	Continued From page 39 -Within 2 or 3 weeks, he began eating in his room and he was not really encouraged to come out of his room due to his strong body odor. -When he began eating in his room all the time, she observed that his appetite decreases dramatically, and he often only took a few bites of his food at each meal. -Resident #1 seemed to stop eating completely 3 or 4 weeks ago. -Sometimes when she took him his meals, he would state he'd already eaten, or that "the Secret Service had already fed him." -Sometimes he would attempt to sit up to eat but would lay right back down without eating anything. -She would take Resident #1's untouched plates to the SCC and say, "he didn't eat anything again" and she would say "wow" but there was never any follow-up on what she was going to do about his decreased appetite. -Resident #1 never had an order for any kind of meal supplement. -Resident #1 was a social person and it seemed like when he became more isolated in his room, he began declining more rapidly and eating less. -When staff observed changes in residents' status, they were supposed to report this to the SCC. -Usually, changes in condition, such as decreased appetite were discussed at stand-up at the beginning of each shift. -She was informed by the MA's, during the stand ups that the MAs would check on any new plans for Resident #1. Interview with a PCA on 07/27/23 at 11:45am revealed: -Resident #1 refused food most of the time the last few months he was in the facility. -Resident #1 would sit up and act like he was	D 273		

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eating but would not put anything in his mouth.
-Resident #1 would sometimes take a sip of juice.
-Staff were directed by the SCC to have Resident #1 eat in his room because his hygiene was poor, and he had body odor.
-Once he started eating in his room, his appetite decreased significantly very quickly.
-Resident #1 often seemed depressed the last few months he was in the facility.
-Staff would take his food to his room and then pick it up at the end of the meal and check on him a few times throughout the meal.
-She would take Resident #1's untouched plates to the SCC and show her he hadn't eaten anything and would also report this at stand-up.
-She suggested maybe Resident #1's appetite had decreased because he had started eating in his room, and that maybe he would eat more if he returned to the dining room, but the SCC never directed staff to start bringing him to the dining room again.
-The last week he was at the facility, she did not observe him to eat anything.
-It was obvious he had lost weight and a few days before he went to the ED she told the HWD that Resident #1's cheek bones were visible, where they had never been before.

Interview with a PCA on 08/02/23 at 2:10pm revealed:
-Resident #1 would sometimes ask for something to drink, but when he brought the drink to him, he would not drink any of it.
-He often took Resident #1's food to him in his room because he refused showers and had strong body odor.
-When he delivered his food to him, he would leave it with him for about 20 minutes and Resident #1 often "would not touch" his food.
-Resident #1 would sit up and look at the food

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and would then lay back down.
-He had attempted on one occasion to provide feeding assistance to Resident #1 and the resident slapped him.
-He had reported that Resident #1 was not eating to the other PCAs, the MAs, and the SCU Director.
-All staff knew he was not eating his meals.
-He started working at the facility at the beginning of June 2023, but in the short time he was there, he could tell that Resident #1 had lost weight.
-Resident #1 never had meal supplements.

Interview with a PCA on 08/02/23 at 3:10pm revealed:
-Resident #1 stopped coming out for meals the last few months he was at the facility and ate in his room; she often took him his meals.
-She had observed that if his food was left with him, he would not eat, but if she stayed with him and encouraged him to eat a little, he sometimes would.
-The last 2 days he was at the facility, he would drink a few sips but would not eat anything, other than a few bites of jello.
-The last month he was at the facility, he would mostly only eat a few bites of his dessert.
-When she observed Resident #1 had not eaten any of his meal, she would report this to the MA, or the LPN and they would go to his room together to try to get him to eat a little food.
-The LPN would let the next shift know if he had not eaten any of his meal.

Telephone interview with geriatric Nurse Practitioner on 08/03/23 10:23am revealed:
-She was asked to see Resident #1 by the ED physician due to concerns for neglect by the facility in which he resided.
-She observed Resident #1 to have a very dry

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mouth and was very unclean in his appearance and had strong body odor.
-She recalled the facility hadreported to EMS that Resident #1 had not eaten or drank anything for 2 days, but from the condition of his mouth and skin, she would estimate Resident #1 had not had any food or drink in approximately a week.
-She attempted to call the facility 5 times to obtain more information, but no one answered the phone at the facility.
-Resident #1 was unresponsive and could only look in her direction. He was not able to verbally respond to any questions.
-Resident #1 should have received medical attention sooner, when the change in condition started.
-If he had received care sooner, he might of had a different outcome.

Telephone interview with the former SCC on 08/03/23 at 12:16pm revealed:
-She had only recently become aware Resident #1 had stopped eating any food, and at that time she spoke with the HWD and the AIT, who recommended Hospice be involved.
-To her knowledge, Resident #1 stopped eating only a few days prior to being sent to the hospital.
-Resident #1 did not require supervision while eating.
-Resident #1 had always been a picky eater only ate 30% - 40% of his meals, and would only eat vegetables, fish, and starches.
-Resident #1 would usually come out of his room and eat a few bites and go back to his room.
-Resident #1 had poor hygiene and strong body odor and other residents complained.
-She had attempted to sit him somewhere different to eat his meals, away from the other residents, but this did not work out.
-Resident #1 already not desiring to come out of

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his room, so staff started taking his meals to him in his room.
-Staff did not record how much of meals residents ate.
-If a resident was not eating their meals, staff were supposed to notify the LPN, who would follow up with the HWD because she was not responsible for notifications.
-She did not notify the HWD about Resident #1's refusals of meals.
-It was the responsibility of the HWD to notify the family, and other support staff as well as to hold a care meeting to discuss Resident #1 not eating.
-The HWD was responsible for notification to Resident #1's PCP related to Resident #1 not eating meals.
-She was never involved in communication related to appetite and nutrition because this was a clinical task for which the HWD was responsible.
-She recalled staff showed her Resident #1's plates at the end of his meal on two occasions a few days prior to him being sent out.
-She did not recall Resident #1 having an order for meal supplements and did not recall him every receiving a meal supplement of any kind.

Interview with the HWD on 07/17/23 at 11:30am revealed:
-Resident #1 began refusing to eat more frequently last week and the facility communicated with the physician and the Responsible Party (RP).
-Tuesday (07/11/23) was the first-time staff documented about his decreased appetite.
-The SCC notified the RP of the change in his appetite on Thursday.
-She had called Resident #1's physician to notify him of the change in appetite.
-When the LPN determined Resident #1 needed

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to be sent to the ED for evaluation on Sunday (07/16/23), she called his RP to notify him of her observations and he told her at that time that he was concerned about him on Friday (07/14/23) when he Facetimed with him because he was "acting different" during the call and "didn't look good."
-The RP had not notified the facility of his concerns prior to the LPN reaching out to him on 07/16/23.
-The RP spoke to the SCU Director "often" about his care.

Telephone interview with Resident #1's RP on 08/03/23 at 8:27am revealed:
-He had a scheduled Facetime visit with Resident #1 every Friday afternoon.
-On Friday 07/14/23, he observed Resident #1 would not sit up like he usually did for their virtual visit and was very lethargic and not responding to him.
-At one point during the call, Resident #1 attempted to sit up, but it only lasted about 8 seconds before he fell back down.
-He observed during the call that Resident #1's arms appeared very slim.
-He called the facility on his cell phone while he was still on the Facetime call on another device with Resident #1.
-He did not recall the name of the staff person he spoke with, but he asked what was going on with Resident #1, and they told him that Resident #1 was "fine but was not eating" and that the facility was going to "take a different approach."
-When he questioned what the different approach would be, the staff member was not able to give him any specifics and told him he would need to speak with the SCC, who was already gone for the day and would return on Monday (07/17/23).
-No one from the facility had ever called him to

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discuss Resident #1's decreased appetite or to tell him that he had stopped eating completely until, he called to inquire about his condition on 07/14/23.
-He had spoken with the AIT on a few occasions over the past few months, related to financial matters, but Resident #1's appetite was never discussed.
-No one from the facility had ever contacted him to inform him that Resident #1 had stopped coming out of his meals.
-Resident #1 had always been a very social person and was always excited to tell him about what he had eaten recently or about events that were happening at the facility.
-He felt the fact that Resident #1 was eating in his room alone the last few months of his life and was not being encouraged to come out to the dining room for meals likely contributed to his depression and his decreased appetite.
-He arrived at the facility on Monday 07/17/23, after Resident #1 was sent out on 07/16/23 and spoke with staff who were unable to tell him if Resident #1 had not eaten anything the day he was sent out. They could tell him that he'd drank "a little" lemonade but no one could answer if he had taken any bites of his sandwich that day for lunch.
-On Saturday (07/15/23), he continued to worry about Resident #1 and called the facility again and spoke with the 1st shift LPN, who also told him they were going to "take a different approach", but she was not able to give him any specifics.
-On Sunday (07/16/23) the 2nd shift LPN called him and said Resident #1 was "not looking good" and asked him if she could send him out.
-He told the LPN that the decision to send Resident #1 out should be made on her judgement because he was not there to assess

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Resident #1 in person and told her she did not need his permission to send him out to the ED for evaluation.
-No one had communicated with him about Resident #1's recent change in condition. When he observed what he felt was a significant change over the Facetime call on Friday (07/14/23) he attempted to reach out to the facility to express his concerns and felt like the facility did not care about Resident #1 or his concerns.

Interview with AIT on 08/03/23 at 3:45pm revealed:
-He had spoken with the SCC and HWD and the regional support staff mainly about Resident #1 refusing personal care.
-It was his understanding that food refusals were new for Resident #1 had had developed just a few days prior to him being sent out to the hospital.
-Residents were supposed to be weighed monthly so the facility could address any patterns of weight loss, but the last documented weight for Resident #1 was in February 2023.
-When Resident #1's intermittent refusals of food began in April and May 2023, the facility should have implemented weekly weight checks for him to more closely monitor his condition.
-Resident #1 was a finicky eater and would not eat meat.
-He thought the facility had offered Resident #1 a meal supplement on a few occasions but was unsure if he had an order or if Resident #1 drank the supplement.
-He was not aware the Occupational Therapist had recommended supervision during meals in March 2023.
-Based on his investigation, he had learned that Resident #1 had eaten about 25% of his meal on Wednesday (07/12/23) at dinner and he was

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

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offered a meal supplement.
-On Thursday (07/13/23) Resident #1 reportedly refused breakfast and lunch.
-He would have like to have seen staff give Resident #1 one more opportunity to eat at dinner on Thursday, and if he hadn't eaten, he would have wanted him to be sent out for evaluation.
-Hospice should have been engaged in March 2023 or earlier in the year based on his general decline related to appetite, medication refusals, refusals of care.
-The HWD had reported to him that she had reached out to the physician regarding his refusals of food but had not gotten a response yet.
-He had not been able to locate any documentation reflecting that the HWD had reached out to the physician.
-The HWD should be reviewing progress notes and following up on any concerning patterns of refusals of food or hydration.

Attempted telephone interview with Resident #1's PCP on 08/02/23 at 3:37pm and 4:02pm and 08/03/23 at 10:45pm and 3:37pm were unsuccessful.

d. Review of Resident #1's record revealed:
-On 10/28/22, was the last documented communication with Resident #1's PCP.
-There was no documentation of communication with the physician from the week of 07/09/23 regarding a change of condition.

Interview with Licensed Practical Nurse (LPN) on 07/17/23 at 2:05pm revealed:
-She was working on 07/16/23 and determined Resident #1 needed to be sent to the ED for evaluation.
-No staff reported any changes with Resident #1

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when she returned on 07/15/23 at the beginning of her shift.
-On Saturday (07/15/23), she observed Resident #1 stayed in bed all day, did not want to try to get up, and a very "weak voice."
-She reported her observations to the oncoming MA at the end of her shift, and the MA told her that he had been refusing food and drink for a few days.
-On Sunday (07/16/23), she observed Resident #1 remained in bed and was not really moving and could not talk at all and was not really responding to her.

Telephone interview with the Geriatric Nurse Practitioner on 08/03/23 10:23am revealed:
-She was asked to see Resident #1 by the ED physician due to concerns for neglect by the facility in which he resided.
-Resident #1 was unresponsive and could only look at my direction. He was not able to verbally respond to any questions.
-She spoke with Resident #1's RP to try to obtain information since she could not reach anyone at the facility, and he reported to her that he had Facetimed with Resident #1 on Friday (7/14/23) and that he lethargic at that time.
-Resident #1's RP told her that he had reached out to the nurse to find out what was going on after his call on Friday afternoon but was never given any clear answers about Resident #1's condition.
-Resident #1 should have received medical attention sooner, when the change in condition started.
-If he had received care sooner, he may have had a different outcome.

Telephone interview with the former SCC on 08/03/23 at 12:16pm revealed:

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-Resident #1 did not exhibit any significant changes until the Thursday (07/13/23) prior to being sent out on 07/16/23, when he completely stopped eating.
-Resident #1 had eaten very little for a few days prior to 07/13/23.
-She notified the RCC and AIT that Resident #1 was not eating on 07/13/23, and the AIT recommended getting Hospice involved as soon as possible.
-She had not reached out to Hospice yet at the time Resident #1 was sent to the hospital on 07/16/23.

Interview with AIT on 07/27/23 at 10:15am revealed:
-In the week leading up to Resident #1 being sent out to the ED for evaluation, there had been no significant changes in his condition.
-On Tuesday (07/11/23) and Wednesday (07/12/23) a MA documented he refused his breakfast, but there was documentation on Thursday (07/13/23) that he had eaten a little bit of a meal, about 10%.
-On Friday (07/14/23), Resident #1 had a Facetime visit with his RP and the RP expressed concern to the PCA who was assisting him with the Facetime visit, that Resident #1 "didn't look good" and she told him that he looked "about the same" as he had recently, and she thought he was okay.
-On Saturday (07/15/23), an LPN spoke with Resident #1's RP when he called to check on him and she reported to him that he looked "about the same" and there were no new concerns.
-On Sunday (07/16/23), the 2nd shift LPN felt like there had been a significant change from what 1st shift had reported to her and made the decision to send Resident #1 out for evaluation.
-The facility should have attempted to engage

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D 273	Continued From page 50 Hospice much sooner, in early April, when staff began observing his general decline in personal care, hygiene, medication refusals, and intermittent refusals of food. -He expected staff to report any concerns with residents to their superior, until it reached him, if necessary, for the issue to be addressed. -He was not aware Resident #1 was refusing medications and food regularly prior to the week before he was sent out. -Resident #1's PCP should have been notified when Resident #1 started not bathing, eating, isolating himself or not taking his medications. Attempted telephone interview with Resident #1's PCP on 08/02/23 at 3:37pm and 4:02pm, and on 08/03/23 at 10:45pm and 3:37pm were unsuccessful. _____ The facility failed to notify Resident #1's PCP when he began refusing medications, personal care, meals documented weight loss of 19 pounds, and increased self isolation leading to significant changes in his condition resulting in the resident being hospitalized with sever dehydration, hypoxia, septic shock along with bacterial pneumonia, acute kidney failure where he remained for 3 days and then passed away. This failure of the facility resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on July 17, 2023 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 2, 2023.	D 273		

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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: Based on observations, interviews and record reviews, the facility failed to administer a medication as ordered for 1 of 5 sampled residents (Resident #5) related to a medication used to treat fluid retention. The findings are: Review of Resident #5's current FL2 dated 03/27/23 revealed diagnoses included chronic kidney disease stage 4 and congestive heart failure. Review of Resident #5's physician's orders dated 05/09/23 revealed: -There was an order for torsemide (a medication used to treat fluid retention caused by congestive heart failure and kidney disease) 20mg take 1 tablet daily as needed (PRN) if the daily weight gain was 3 pounds (lbs) or greater. -There was an order for daily weights and if the weight gain was greater than 2 lbs administer torsemide 20mg. Review of Resident #5's June 2023 electronic medication administration record (eMAR)	D 358		

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revealed:
-There was an entry for torsemide 20mg take 1 tablet daily PRN if the daily weight gain was 3 lbs or greater.
-There was documentation of a 25.6 lb weight gain from 06/07/23 to 06/08/23 and there was no documentation torsemide 20mg was administered.
-There was documentation of a 12.8 lb weight gain from 06/14/23 to 06/15/23 and there was no documentation torsemide 20mg was administered.
-There was documentation of a 5 lb weight gain from 06/16/23 to 06/17/23 and there was no documentation torsemide 20mg was administered.

Observation of Resident #5's medications on hand on 08/03/23 at 10:56am revealed there were no medications available to administer to Resident #5.

Interview with a medication aide (MA) on 08/03/23 at 10:56am revealed Resident #5's medications were returned to the facility's contracted pharmacy since Resident #5 was admitted to the local hospital on 07/07/23 and had not returned to the facility.

Review of Resident #5's chart notes revealed on 06/17/23 at 10:25am, Resident #5 was lying in the bed with his feet hanging off the bed and his feet were swollen.

Review of Resident #5's incident and accident report dated 06/18/23 at 9:01pm revealed:
-The second shift MA found Resident #5 unarousable and telephoned the first shift MA which reported she found Resident #5 unarousable with delayed responses, hanging

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halfway off the bed, his feet were "severely" swollen and "looked like they were going to pop open".
-The first shift MA reported staff continued to monitor Resident #5 throughout the day and Resident #5 became delusional and disoriented.
-Resident #5 was transported to the local hospital emergency department (ED) for a medical evaluation by the second shift MA.

Telephone interview with a MA on 08/02/23 at 4:00pm revealed:
-She remembered administering Resident #5 torsemide 20mg on 06/08/23 and did not know why the torsemide was not documented as administered.
-She remembered administering Resident #5 torsemide 20mg on 06/15/23 and she thought she did not document the torsemide as administered because it was a PRN medication.
-She was certain she administered torsemide 20mg to Resident #5 on 06/08/23 and 06/15/23 with a weight gain of 3 lbs or greater in a day, but just forgot to document the torsemide as administered.
-She knew she was supposed to document the administration of medications to residents per the facility's Medication Administration policy.

Telephone interview with a second MA on 08/02/23 at 4:17pm revealed:
-She did not know if she administered torsemide 20mg to Resident #5 on 06/17/23 for a 5 lb weight gain in one day.
-When she administered Resident #5's PRN torsemide, she documented the administration of the medication on the eMAR.
-She thought she "missed" Resident #5's five pound weight gain in a day and did not administer torsemide to Resident #5 on 06/17/23.

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D 358	Continued From page 54 Telephone interview with Resident #5's power of attorney (POA) on 08/03/23 at 12:03pm revealed: -She visited Resident #5 about 8-10 times per month. -She thought Resident #5 was administered all his medications. -Resident #5 had an extensive health history and was hospitalized on multiple occasions in the past 3 months. -Resident #5 was hospitalized in June 2023 for hallucinations. -On 06/14/23, Resident #5 was hospitalized again and received hemodialysis. -On 07/07/23, Resident #5 was readmitted to the hospital for hallucinations and stroke like symptoms and was discharged to a local rehabilitation facility on 08/02/23. Interview with the Regional Director of Operations on 08/03/23 at 4:00pm revealed: -She was not aware Resident #5 was not administered torsemide 20mg on 06/08/23, 06/15/23, and 06/17/23 with a weight gain of 3 lbs or greater in a day. -The facility's policy for medication administration included to administer medications as ordered or call the primary care provider (PCP) to receive additional orders. -Any medication refusals or when a medication was not administered should have been documented as not administered and a comment should have been added to explain the reason the medication was not given. -She expected the MAs to follow the facilty's policy and administer medications as ordered. Interview with the Administrator-In-Training on 08/03/23 at 4:30pm revealed: -He was not aware Resident #5 was not	D 358		

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D 358	Continued From page 55 administered torsemide 20mg PRN with a daily weight gain of 3 lbs or greater on 06/08/23, 06/15/23, and 06/17/23. -The facility's policy for medication administration included administering medications as ordered. -He expected staff to administer medications as ordered. -The Health and Wellness Director (HWD) was responsible to monitor the eMARs for accuracy daily Monday through Friday and should have found Resident #5 was not administered the ordered torsemide for weight gain. -He did not know why the former HWD did not notice Resident #5 was not administered torsemide 20mg on 06/08/23, 06/15/23, and 06/17/23 with a daily weight gain of 3 lbs or greater. -The facility did not have a HWD currently. Attempted interview with Resident #5 on 08/01/23 at 10:08am was unsuccessful due to being out of the facility. Attempted telephone interview with Resident #5's PCP on 08/03/23 at 12:48pm was unsuccessful.	D 358		
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 develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of	D 464		

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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 reviews and interviews, the facility failed to ensure 1 of 4 sampled residents Special Care Unit (SCU) Care Plan was signed by a physician within 15 days of completion (Resident #1).

Review of Resident #1's current FL2 dated 03/26/22 revealed:
-Diagnoses included neurocognitive disorder, major depressive disorder, hypertension, hyperlipidemia, history of recurrent urinary tract infections, and open angle glaucoma.
-Resident #1 required SCU level of care.
-Resident #1 was intermittently disoriented and was a wanderer.
-Resident #1 was ambulatory, incontinent of bladder, and continent of bowel.
-Resident #1 required assistance with bathing and dressing.

Review of Resident #1's resident register revealed he was admitted on 02/01/18.

Review of Resident #1's SCU profile dated 04/04/23 revealed:
-Resident #1 wandered "at times."
-Resident #1 was verbally abusive and could use

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foul language when staff tried to perform activities of daily living (ADLs).
-Resident #1 refused medications.
-Resident #1 refused personal care.
-There were no specific interventions to be used to address Resident #1's documented behaviors.
-Resident #1 required assistance with dressing, grooming, toileting and bathing.
-Resident #1 was independent with eating and ambulation.

Review of Resident #1's Care Plan dated 05/03/23 revealed:
-It was not signed by the primary care provider (PCP).
-Resident #1 required assistance with dressing and bladder hygiene.
-Resident #1 required full assistance with personal hygiene.
-Resident #1 required reminders for bathing, as well as stand-by assistance while he was bathing.
-Resident #1 required multiple attempts for hygiene purpose and was resistant to bathing assistance.
-Resident #1 required reminders with toileting.
-Resident #1 "manages regular resistance to care or assistance independently or with intervention; multiple attempts required for hygiene purposes."
-The care plan did not include or specify programming needs that involved environmental, social, and health care strategies to maintain and maximize Resident #1's level of functioning based on his SCU profile.

Interview with the former Special Care Coordinator (SCC) on 08/03/23 at 12:16pm revealed:
-She was not aware Resident #1 did not have a signed Care Plan.
-The Health and Wellness Director (HWD) was

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D 464	Continued From page 58 responsible for completing resident Care Plans and for communicating with physicians to obtain a signature. Attempted telephone interview with the HWD on 08/03/23 at 3:26pm was unsuccessful. Interview with the Administrator-In-Training on 08/03/23 at 3:45pm revealed: -He was not aware Resident #1 did not have a signed care plan. -The HWD was responsible for completing Care Plans annually and as needed for residents. -His expectation was that the HWD would document all communication attempts with physicians for residents.	D 464		