STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7.1.2 . 2.1.		152111110711101111011152111	A. BUILDING: _		R	
		FCL060019	B. WING	B. WING		3/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SHADY H	ARBOUR ADULT LIVING		IUNTER ROAD			
	OUR MAN DV OT		TE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	The Adult Care Licens annual survey on Apri	sure Section conducted an Il 23, 2024.				
C 203	10A NCAC 13G .0702 Medical Examination	2 (b) Tuberculosis Test And	C 203			
	10A NCAC 13G .0702 Medical Examination	2 Tubercluosis Test And				
	(b) Each resident sha examination prior to a annually thereafter.	all have a medical dmission to the home and				
	facility failed to ensure	as evidenced by: ews and interviews, the e a resident's FL2 was 1 of 3 sampled residents.				
	The findings are:					
	Review of Resident # 04/18/23 revealed dia osteoarthritis, diabete disorder.					
	Review of Resident # revealed an admissio	<del>-</del>				
	Review of Resident # revealed there was no completed since 04/1	•				
	Interview with the medo4/23/24 at 1:54pm a -She was not aware F been updated annual -The Administrator inf	nd 5:05pm revealed: Resident #2's FL2 had not y.				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL060019	B. WING		04	R J <b>/23/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
SHVDA H	ARBOUR ADULT LIVING	908 TOM	HUNTER ROAD			
SHAUTH	ARBOUR ADULT LIVING	CHARLO	TTE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 203	resident's FL2 needed the form for the Admirator was FL2 signed by the result of Provider (PCP).  -She was not aware of completed to ensure completed annually.  Interview with the Admirator of	d updated, and she filled out nistrator. as responsible for getting the sident's Primary Care of any chart audits resident FL2s were ministrator on 04/23/24 at revealed: Resident #2's FL2 had not 14/18/23.	C 203			
C 231	10A NCAC 13G .080° (b) The facility shall a each resident is comp following admission a thereafter using an as established by the Department of the established by the Department of the established on the	and at least annually assessment instrument artment or an instrument artment based on it as same information as lished instrument. The appleted within 30 days and annually thereafter shall asment to determine a actioning to include and cognitive status and a activities of daily living. It is gare bathing, dressing, abulation or locomotion, and eating. The icate if the resident requires	C 231			

Division of Health Service Regulation

STATE FORM 6899 HPHQ11 If continuation sheet 2 of 7

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING:		R	
		FCL060019	B. WING	B. WING 04		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SHADY H	ARBOUR ADULT LIVING	908 TOM	HUNTER ROAD			
		CHARLO	TE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
C 231	Continued From page	e 2	C 231			
		pmental disabilities or				
	facility failed to ensur	as evidenced by: and record reviews, the e a care plan was completed ampled residents (#2).				
	The findings are:					
	Review of Resident #2's current FL2 dated 04/18/23 revealed diagnoses included osteoarthritis, diabetes, and schizoaffective disorder.					
	Review of Resident #2's Resident Register revealed an admission date of 08/08/19.					
		2's record on 04/23/24 ot an updated care plan 6/22.				
	not been updated and and a resident's care plan in filled out the form for a remarked and a remarked and a resident's care plan signed by the provider (PCP).  She was not aware of completed to ensure completed annually.	nd 5:05pm revealed: Resident #2's care plan had hually. formed her when a eeded updated, and she the Administrator. as responsible for getting the he resident's Primary Care of any chart audits resident care plans were				
	Interview with the Adr 1:45pm and 5:12pm r	ministrator on 04/23/24 at revealed:				

Division of Health Service Regulation

STATE FORM 6899 HPHQ11 If continuation sheet 3 of 7

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_			
		ECI 060040	B. WING		R	
		FCL060019			04/23/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
CHVDA H	ADDOLID ADULT LIVING	)				
SHADIR	ARBOUR ADULT LIVING	CHARLO	TTE, NC 28213			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE DATE	
				DEI IOIEITOT)		
C 231	Continued From page	e 3	C 231			
	Cha was not awars [	Pasidant #2's care plan had				
	not been updated sin	Resident #2's care plan had				
	•					
		e for ensuring the residents'				
	care plans were comp	pieted annually.				
C 375	10A NCAC 13G .1009	9(a)(1) Pharmaceutical Care	C 375			
	404 NOAO 400 400	D. Di				
		9 Pharmaceutical Care				
	(a) The facility shall obtain the services of a					
	licensed pharmacist, prescribing practitioner or					
	registered nurse for the provision of					
	pharmaceutical care at least quarterly for residents or more frequently as determined by					
		· · · · · · · · · · · · · · · · · · ·				
		ed on the documentation of				
		problems identified during				
		her investigations in which				
	the safety of the resid	ients may be at risk. involves the identification,				
		ition of medication related				
	-	des at least the following:				
	-	tion review for each resident				
	, ,					
	which includes at least the following: (A) the review of information in the resident's					
	, ,					
	record such as diagnoses, history and physical, discharge summary, vital signs, physician's					
	orders, progress notes, laboratory values and					
		ation records, including				
		Iministration records, to				
		ations are administered as				
	prescribed and ensure that any undesired side effects, potential and actual medication reactions					
	or interactions, and m					
	identified and reporte					
	prescribing practition					
		ndations for change, if				
	necessary, based on					
	•	ng that the appropriate				
		er is so informed; and,				
	(C) documenting the results of the medication					

Division of Health Service Regulation

STATE FORM 6899 HPHQ11 If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(Y2) MIJI TIDI E	CONSTRUCTION	(V2) DATE SI	IIDVEV
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING: _				
				R		
FCL060019		B. WING		04/2	3/2024	
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
			IUNTER ROAD			
SHADY HA	ARBOUR ADULT LIVING		TE, NC 28213			
	OLIMANA DV OT		T	PROMPERIO PLAN OF CORRECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
C 375	Continued From page	<u>.</u> 4	C 375			
	review in the resident	's record;				
	This Pula is not mot	as avidanced by:				
	This Rule is not met a	as evidenced by. and record reviews the				
		e a licensed pharmacist,				
	provider or registered					
		ication review for 3 of 3				
	sampled residents (#					
		,				
	The findings are:					
		t #1's current FL2 dated				
	02/07/24 revealed:					
	-Diagnoses included I	bipolar 1 disorder and				
	memory loss.	witted to the facility on				
	-Resident #1 was adn	mitted to the facility on				
	11/01/23.					
	Review of Resident #	1's record on 04/23/24				
	revealed:	10100014 011 0 1/20/21				
		nitted to the facility on				
	11/01/23.	•				
	-There were no medic	cation reviews available for				
	review.					
		h the mediation aide (MA) on				
	04/23/24 at 5:05pm.					
	Defer to intensions	h the Administrator on				
	04/23/24 at 1:45pm a					
	04/23/24 at 1.43pm a	па э. гарит.				
	2. Review of Resident	t #2's current FL2 dated				
	04/18/23 revealed:	t ,, 2 5 dan one i 22 datou				
	• ., . •, = •	osteoarthritis, diabetes, and				
	schizoaffective disord					
		nitted to the facility on				
	08/18/19.	•				

Division of Health Service Regulation

Review of Resident #2's record on 04/23/24

STATE FORM 6899 HPHQ11 If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7.1.2 . 2.1.			A. BUILDING: _			
		FCL060019 B. WING		R <b>04/23/2024</b>		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADD			TE, ZIP CODE		
SHADY HARBOUR ADULT LIVING			HUNTER ROAD			
			TE, NC 28213			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE	
C 375	Continued From page	5	C 375			
	revealed there were to dated 08/23/22 and 0 review.	wo medication reviews, 9/22/23, available for				
	Refer to interview with 04/23/24 at 5:05pm.	n the mediation aide (MA) on				
	Refer to interview with the Administrator on 04/23/24 at 1:45pm and 5:12pm.  3. Review of Resident #3's current FL2 dated 11/28/23 revealed: -Diagnoses included post (after) stroke adjustment disorder, major depression disorder and type 2 diabetesResident #3 was admitted to the facility on 07/24/23.					
	revealed:	3's record on 04/23/24				
	-Resident #3 was admitted to the facility on 07/24/23There were no medication reviews available for					
	Refer to interview with 04/23/24 at 5:05pm.	n the mediation aide (MA) on				
	Refer to interview with 04/23/24 at 1:45pm a	n the Administrator on nd 5:12pm.				
	revealed: -The Administrator was medication reviews w -She was not aware of completed to ensure a completed quarterly.	as responsible for ensuring ere completed quarterly. of any chart audits medication reviews were				

Division of Health Service Regulation

STATE FORM 6899 HPHQ11 If continuation sheet 6 of 7

PRINTED: 05/13/2024 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED			
						R		
		FCL060019	B. WING		04	/23/2024		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SHADY H	SHADY HARBOUR ADULT LIVING 908 TOM HUNTER ROAD CHARLOTTE, NC 28213							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE		
C 375	1:45pm and 5:12pm r -She scheduled reside the contracted pharm -She called the pharm was informed the pha medication reviews w -She was not aware to was completed 09/22.	evealed: ent pharmacy reviews with acy when they were due. nacy that day (04/23/24) and rmacist that did the facility's as not working that day. he last pharmacy review /23. for ensuring medication	C 375					

Division of Health Service Regulation

STATE FORM 6899 HPHQ11 If continuation sheet 7 of 7