STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060018	A. BUILDING: _____ B. WING _____	R 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY HARBOUR ADULT LIVING	906 TOM HUNTER ROAD CHARLOTTE, NC 28213

(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) COMPLETION DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 23, 2024.	C 000		
C 203	10A NCAC 13G .0702 (b) Tuberculosis Test And Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination (b) Each resident shall have a medical examination prior to admission to the home and annually thereafter. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a resident's FL2 was updated annually for 1 of 3 sampled residents. 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. Review of Resident #2's record on 04/23/24 revealed there was not an updated FL2 completed since 04/18/23. Interview with the medication aide (MA) on 04/23/24 at 1:54pm and 5:05pm revealed: -She was not aware Resident #2's FL2 had not been updated annually. -The Administrator informed her when a	C 203	Adm. will make sure 5/19/2024 all Residents have a current updated TB Step 2 Examination and FL2. addendum to tag C 203 per telephone conversation with Ms. Osborne, administrator, on 06/21/24 at 12:06 PM: - The FL2 was completed on 04/30/24. - a calendar was put in place to ensure FL2s are updated annually. - The administrator will monitor the calendar monthly. - The date of correction was 05/19/24. Sharon Dunton RN 06/21/24	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER'S OR PLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator/Owner 5/19/2024

STATE FORM 6899 HHHQ11 If continuation sheet 1 of 7

The Plan of Correction with addendum was reviewed and acknowledged on 06/21/24. Refer to addendums on pages 1, 2, 3, 4 and 5 of this Statement of Deficiencies.

Sharon Dunton RN 06/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060019	A. BUILDING: _____ B. WING _____	R 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY HARBOUR ADULT LIVING	908 TOM HUNTER ROAD CHARLOTTE, NC 28213

(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
C 203	Continued From page 1 resident's FL2 needed updated, and she filled out the form for the Administrator. -The Administrator was responsible for getting the FL2 signed by the resident's Primary Care Provider (PCP). -She was not aware of any chart audits completed to ensure resident FL2s were completed annually. Interview with the Administrator on 04/23/24 at 1:45pm and 5:12pm revealed: -She was not aware Resident #2's FL2 had not been updated since 04/18/23. -She was responsible for ensuring the residents' FL2s were compieted annually.	C 203		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801 Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of	C 231	Admin. will Assure All Care plans are Completed Annually, Signed by Doctor. Training will be Conducted on Care plans addendum to tag C231. Per telephone conversation with Ms. Osborne, Administrator, on 06/21/24 at 12:06 PM: - The Care Plan was completed on 04/30/24.	5/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060019	A. BUILDING: _____ B. WING _____	R 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY HARBOUR ADULT LIVING	908 TOM HUNTER ROAD CHARLOTTE, NC 28213

(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
C 231	Continued From page 2 mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a care plan was completed annually for 1 of 3 sampled 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. Review of Resident #2's record on 04/23/24 revealed there was not an updated care plan completed since 12/06/22. Interview with the medication aide (MA) on 04/23/24 at 1:54pm and 5:05pm revealed: -She was not aware Resident #2's care plan had not been updated annually. -The Administrator informed her when a resident's care plan needed updated, and she filled out the form for the Administrator. -The Administrator was responsible for getting the care plan signed by the resident's Primary Care Provider (PCP). -She was not aware of any chart audits completed to ensure resident care plans were completed annually. Interview with the Administrator on 04/23/24 at 1:45pm and 5:12pm revealed:	C 231	- a calendar was put in place to ensure care plans are updated annually. - The Administrator will monitor the calendar monthly. - The date of correction was 05/19/24 — Sharon Dantzler RN 06/21/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060019	A. BUILDING: _____ B. WING _____	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY HARBOUR ADULT LIVING	908 TOM HUNTER ROAD CHARLOTTE, NC 28213

(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
C 231	Continued From page 3 -She was not aware Resident #2's care plan had not been updated since 12/06/22. -She was responsible for ensuring the residents' care plans were completed annually.	C 231		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 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 the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication 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 medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication	C 375	Facility will Assure Quarterly pharmacy Reviews Are completed on each Resident. will follow up on recommendations. Pre schedule pharmacy visits. addendum to tag C 375: per telephone conversation with Ms Osborne, administrator, on 06/21/24 at 12:06 pm: - a pharmacy review was completed on 05/22/24. - The administrator will pre-schedule pharmacy quarterly visits.	5/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060019	A. BUILDING: _____ B. WING _____	R 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY HARBOUR ADULT LIVING	908 TOM HUNTER ROAD CHARLOTTE, NC 28213

(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
C 375	Continued From page 4 review in the resident's record; This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure a licensed pharmacist, provider or registered nurse completed a quarterly on-site medication review for 3 of 3 sampled residents (#1, #2, and #3). The findings are: 1. Review of Resident #1's current FL2 dated 02/07/24 revealed: -Diagnoses included bipolar 1 disorder and memory loss. -Resident #1 was admitted to the facility on 11/01/23. Review of Resident #1's record on 04/23/24 revealed: -Resident #1 was admitted to the facility on 11/01/23. -There were no medication reviews available for review. Refer to interview with the mediation aide (MA) on 04/23/24 at 5:05pm. Refer to interview with the Administrator on 04/23/24 at 1:45pm and 5:12pm. 2. Review of Resident #2's current FL2 dated 04/18/23 revealed: -Diagnoses included osteoarthritis, diabetes, and schizoaffective disorder. -Resident #2 was admitted to the facility on 08/18/19. Review of Resident #2's record on 04/23/24	C 375	- a calendar was put in place to ensure pharmacy reviews are completed quarterly. - The administrator will monitor the calendar Monthly. - The date of correction was 05/29/24. Sharon Dantzler 06/21/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060019	A. BUILDING: _____ B. WING _____	R 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY HARBOUR ADULT LIVING	908 TOM HUNTER ROAD CHARLOTTE, NC 28213

(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
C 375	Continued From page 5 revealed there were two medication reviews, dated 08/23/22 and 09/22/23, available for review. Refer to interview with the mediation aide (MA) on 04/23/24 at 5:05pm. 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 diabetes. -Resident #3 was admitted to the facility on 07/24/23. Review of Resident #3's record on 04/23/24 revealed: -Resident #3 was admitted to the facility on 07/24/23. -There were no medication reviews available for review. Refer to interview with the mediation aide (MA) on 04/23/24 at 5:05pm. Refer to interview with the Administrator on 04/23/24 at 1:45pm and 5:12pm. Interview with the MA on 04/23/24 at 5:05pm revealed: -The Administrator was responsible for ensuring medication reviews were completed quarterly. -She was not aware of any chart audits completed to ensure medication reviews were completed quarterly. Interview with the Administrator on 04/23/24 at	C 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060019	A. BUILDING: _____ B. WING _____	R 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY HARBOUR ADULT LIVING	908 TOM HUNTER ROAD CHARLOTTE, NC 28213

(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
C 375	Continued From page 6 1:45pm and 5:12pm revealed: -She scheduled resident pharmacy reviews with the contracted pharmacy when they were due. -She called the pharmacy that day (04/23/24) and was informed the pharmacist that did the facility's medication reviews was not working that day. -She was not aware the last pharmacy review was completed 09/22/23. -She was responsible for ensuring medication reviews were completed quarterly.	C 375		