STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 the Mecklenburg County Department of Social Services conducted an annual survey and complaint investigation on 7/06/16 - 07/08/16. The complaint investigations were initiated by Mecklenburg County Department of Social Services on 6/3/16, 6/7/16, and 6/14/16.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record review, the facility failed to ensure the level of supervision for the residents was modified after two altercations between 2 of 8 (#9 and #11) sampled Special Care Unit (SCU) residents with one altercation resulting in 27 staples to the scalp repeated falls for 1 of 8 sampled residents (#9) with one fall resulting in 11 staples to the scalp and a subsequent fall resulting in a hospitalization for both hydropneumothorax (air and fluid within the pleural space surrounding the lung) secondary to 3 broken ribs. The findings are: A. Review of Resident #9's current FL2 dated 5/30/16 revealed:	D 270	(PLEASE SEE ATTACHED INFORMATION) Addendum made to POC on this tag per telephone conversation 8.18.16 11:23 am KB	8/12/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: W. Fugate TITLE: Executive Director (X6) DATE: 08/12/2016

Reviewed + Accepted c Revisions
KB 8-19-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 1 -Diagnoses included scalp laceration, dementia, aortic stenosis, osteoporosis and glaucoma. 1. Review of Resident #9's Resident Profile dated 2/10/16 revealed: -Resident #9 forgot to use his walker and needed to be reminded to use his walker and has "very unsteady gait" had several falls due to unsteady gait. -Resident #9 was assessed as independent with ambulation with walker. -Resident #9 was assessed as having no physical problems. -Resident #9 was not under the care of the facility's in-house physical therapy department with a recommendation that he should be evaluated due to re-current falls. Review of Resident #9's Progress Notes revealed: -On 5/27/16, Resident #9 fell in the dining room at 9:00 am and there were no known injuries. -On, 5/29/16, Resident #9 was found on the floor next to his bed, bleeding profusely from an injury to his head and was sent to the local hospital emergency department. -On 5/30/16, Resident #9 returned from the hospital with staples to his scalp, acute blood loss and Resident #9 was "under two hour monitoring and checks." -There was no documentation reflecting the two hour checks after Resident #9 returned fro the hospital. -On 7/02/16 Resident #9 was found on the floor in his room and had sustained another head injury and sent to the local hospital emergency department. Review of Resident #9's Discharge Summary dated 5/29/16 revealed:	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 2 -Resident #9 had numerous falls per the nursing facility as well as worsening dementia over the last month. -Resident #9 lost approximately 1 liter of blood from a scalp laceration and received two units of packed red blood cells. -The cause of the fall was suspected to be mechanical in nature but the syncopal episodes were likely to progress due to severe aortic stenosis. -The was no acute fractures but there was an extensive scalp injury which was closed with sutures and 11 staples. Review of Resident #9's Physician's Visit Summary dated 5/31/16 revealed: -The aspirin (used as a blood thinner) was discontinued due to the risk of falling and bleeding. -The physician advised the facility staff to keep the "patient" monitored at all times due to his recent increase in falls. -Resident #9 was not a candidate for physical therapy as he would not follow the commands of the physical therapist and therapy had been attempted in the past. Review of Resident #9's record revealed: -On 6/03/16 Resident #9 was ordered to have a urinalysis with culture and sensitivity. -There was no entry indicating a specimen was obtained, sent to the laboratory or results were obtained and reviewed by a physician. Review of Resident #9's Emergency Department Physician Documentation dated 7/02/16 revealed: -Resident #9 had suffered a fall at his facility that evening and he also had a fall earlier that day in which he had sustained an injury to his great toe. -Over the last several weeks Resident #9 had	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 3 been more prone to falls. -The fall that evening resulted in a laceration to his head and 3 left-sided rib fractures that led to fluid in his chest causing a hydropneumothorax (air and fluid within the pleural space surrounding the lung secondary). -His dressing came off while in radiology and he lost approximately 300-400 cc of blood and received a blood transfusion. -He was then transferred to a different hospital for a higher level of care and a geriatric trauma assessment. Review of the Hospital Discharge Summary Report dated 7/08/16 revealed: -Resident #9 was admitted to the Intensive Care Unit (ICU) to manage the rib fractures and hydropneumothorax. -After two days without significant issues he was tranferred to the medical floor. -Physical therapy evaluated Resident #9 and determined he would benefit from continued therapy. -He was still in the hospital but was deemed stable for discharge on 7/08/16. Review of an email sent to the facility's Director of Operations from the Multi-Site Manager of the in-house physical therapy department dated 7/08/16 revealed: -Resident #9 "was under question as to therapy services in September of 2015". -He had not received any therapy due to the declination of the Responsible Party (RP). Interview with the facility's Director of Clinical Services on 7/08/16 at 2:50 pm revealed: -Resident #9's RP refused the physical therapy because they did not want to pay the co-pay. -She did not know how the in-house physical	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 4 therapy department billed or why there would be a co-pay for a resident that received medicare. -She did not know if other agencies were contacted for the referral. Interview with Resident #9's RP on 7/07/16 at 6:00 pm revealed: -Resident #9 often refused to use his cane and walker. -He did not believe there were interventions put in place to prevent falls. -The faclity did move the nightstand away from the bed to reduce possible injury. -They did move a pillowed recliner next to the bed to help protect him from a fall. -Resident #9 never had physical therapy. -The RP thought the facility should check in on the residents more. -He would visit Resident #9 for 2 hours and on very few occasions did staff even peak in to check on Resident #9. -The RP visited Resident #9 a few months ago and Resident #9 was not in his room. The staff had no idea where he was and one of the staff members helped him search for Resident #9. -After a search of the unit they went outside and Resident #9's walker was on its side and Resident #9 was found laying on the ground behind a bush and had fallen asleep. -He did not report this incident to the Administrator. Review of Resident #9's Incident Reports revealed: -There was no incident report or post fall investigation to correspond with the documented fall on 5/27/16. -There was an incident report dated 5/29/16 which documented Resident #9 fell in his room, the fall was unwitnessed and he was sent to the	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 5 local hospital for emergency care for a head injury (injury type noted as laceration with concussion). -There was no post fall investigation form that corresponded with the 5/29/16 to reflect interventions implemented to prevent falls. -There was an incident report dated 7/02/16 which documented Resident #9 fell in his room, the fall was unwitnessed and he was sent to the local hospital for emergency care for a head injury. -There was a corresponding post fall investigation form which documented Resident #9 was at risk for falls and had suffered previous falls within the last 90 days which resulted in a head injury, Resident #9 sustained an injury to the head with this fall, the fall was unwitnessed and Resident #9 was transported to the hospital. It was documented Resident #9 was independent with ambulation with a walker and Resident #9 was last toileted at 9:00 pm. -The second page which included spaces for interventions was left blank and as it was documented Resident #9 remained hospitalized and they were to evaluate upon return. Review of Resident #9's record revealed there was no documented interventions that were devised or revised to prevent Resident #9 from falling. Interview on 7/6/16 at 6:20 pm with a Personal Care Aide in the SCU revealed: -She was not aware of a written fall policy. -If a resident sustained a head injury or the fall was unwitnessed, staff would send the resident to the local hospital emergency department for evaluation. -If a resident had a fall with no apparent injury, staff would check vital signs and monitor the	D 270	PLEASE SEE ATTACHED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 6 resident for 24-48 hours every 30 minutes to hourly. -If the resident had no behavior changes and no other falls after 24-48 hours, then staff would go back to monitoring every 2 hours. -Staff were supposed to complete an Accident & Incident report for all falls regardless if the resident was sent out to the local hospital emergency department or not. Interview with a Medication Aide (MA) on 7/08/16 at 12:38 pm revealed: -When a resident falls the staff was expected to assess for injuries. -If the resident hit their head or sustained an injury they were to send the resident to the local hospital emergency department. -After a fall or when the resident returned from the hospital they were expected to monitor the resident every shift for 72 hours. -This monitoring should be documented in the nurses' notes. -She did not know why Resident #9's 72 hour shift monitoring was not in Resident #9's nurses' notes. Interview with the SCU Resident Care Director on 7/08/16 at 1:09 pm revealed: -She was not employed at the facility at the time of Resident #9's fall in May and had only been employed about a month. -After a fall she was responsible for following up on all incident reports within 24 hours. -She would call the resident's primary care physician and report the falls. -She would do an environmental assessment to ensure the fall was not caused by an environmental factor such as long pants, slick shoes and wet floors and would make the changes necessary to ensure the safety of the	D 270	PLEASE SEE ATTACHED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 7 resident(s). -She would also look at the medications, medication changes and laboratory orders to ensure that nothing medical or pharmacological was causing the falls. -The staff were expected to monitor the residents who fell every two hours for 72 hours. -There was not a specific form to document the monitoring. -She expected staff document the monitoring in the nurses' notes. Interview with the Administrator on 7/08/16 at 2:39 pm revealed: -After a fall she expected the staff to assess for risk factors such as medications and the environment. -She expected staff check the resident for safety every shift and expected this to be documented in the resident's nurses' notes. -They would discuss the falls in the weekly meetings that took place every Thursday in efforts to develop and/or revise interventions. -She expected that staff would document a fall for 24-48 hours after a fall. -She expected staff to fill out an incident report and this report be faxed to the resident's physician and the local Department of Social Services. -She expected the family to be notified of the incident. Review of the facility fall policy revealed: -Identification of residents who are at risk for falls should occur after the second fall within one calendar month. -A service plan with specific interventions would be developed with the resident/RP by the Resident Care Director. -Facility staff needed to be aware of the specific	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 8 interventions to minimize falls. -Fall interventions would be reviewed for continued effectiveness and revised as indicated. 2. Review of Resident #9's Resident Profile revealed: -Resident #9 was prone to anxiety and had predictable verbal or physically violent behaviors. -He would become agitated when he experienced wartime memories. -He would become physically aggressive when others disagreed with his opinion. -He could be re-directed with constant reminders of staying on task. -He was calmed by talking about his service in the military. -He had struck other residents (men and women) for contradicting him. Review of a Physician's Visit Summary dated 2/05/16 revealed: -Resident #9 had a diagnosis of advanced Alzheimer's dementia and had worsening aggression towards staff and residents. -An order for depakote sprinkles 125mg capsules take 1 capsule twice daily and monitor (a medication used to manage psychotic behavior). Review of Resident #9's Progress Notes revealed: -On 2/09/16 Resident #9 had made a Super Bowl bet with another male resident on the unit. -The other resident went to Resident #9's room to collect his money because he won the bet. -Resident #9 hit the male resident on the side of the face and the male resident hit Resident #9 with both fists which caused his nose to bleed. -On 2/18/16 Resident #9 was very agitated and aggressive trying to hit other residents and staff. He wanted to burn the facility and needed	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 9 matches. He pulled pictures and lamps down. He calmed down on third shift when a staff member arrived and was able to take him to his room. -There was no documentation for the month of March 2016. -On 4/30/16 Resident #9 was involved in a fight with another resident. The altercation caused Resident #9 to fall and hit his head. He returned to the facility with 27 staples in his scalp. -On 5/04/16 Resident #9 began to argue with another resident. He was asked to move to another table to avoid confrontation and refused. He went to his room and refused to eat. -On 5/14/16 Resident #9 had been very combative with staff and other residents. Resident #9 needed to have all canes removed from the room due to using them as hitting sticks. -On 5/18/16 Resident #9 threw water on one of the staff members and "can become very combative at times". He was given an as needed medication and he settled down. Resident #9 apologized to the staff member for throwing the water. -On 5/19/16 Resident #9 had been very combative. -On 6/02/16 Resident #9 was yelling and agitated and requesting to live. He was seen by the contracted psychiatric practitioner and the depakote dose was increased from 250mg 3 times daily to 500mg twice daily and alprazolam XR .5mg (a medication used to treat anxiety) was added in the evening, routinely. Review of the Accident & Incident Report forms revealed: -The Accident & Incident Report form for the 2/09/16 incident was unable to be located. -The Accident & Incident Report form dated 4/30/16 documented Resident #9 was agitated and aggressive and he took a swing at another	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 10 resident. The other resident hit him on the chin which caused him to lose his balance, he fell and hit his head which caused a laceration. He was then sent to the emergency department. Review of Resident #9's record revealed: -A physician's order dated 2/10/16 to obtain a psychiatric referral. -A Physician Assistant Visit Summary dated 2/12/16 which documented Resident #9's case was discussed with the resident and the caretaker. No treatments necessary and the bruising should be resolved within the next 7-10 days. Review of a 24 Hour Report dated 2/10/16 revealed: -On third shift it was documented Resident #9 was on hourly checks and he had a good night. -On first shift it was documented Resident #9 was "OK". -On second shift it was documented Resident #9 was on hourly checks. Review of a police report dated 04/30/16 revealed: -Both residents were in the SCU and had diagnoses of Alzheimer disease. -Resident #11 had walked into the dining room and ran his fingers down the piano keys, this was something he did every morning. -Resident #9 got up from his dining table and came across room and pointed his finger in Resident #11's face and was fussing about the piano. -Resident # 11 punched Resident #9 in the face. -Resident #9 lost his balance and fell striking his head on the table. -According to staff Resident #9 is always getting into altercations with other residents.	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 11 -Resident #11 had never had any problems at the facility. -The case was closed on 04/30/16. Resident #9 was in the hospital on 7/08/16 and not available for interview. Interview with Resident #9's Responsible Party on 7/07/16 at 6:00pm revealed: -Resident #9 had always been argumentative and stubborn. -He did not know if there was increased supervision after the altercations. -He did know that there were medication changes made in efforts to curb Resident #9's aggressive behavior. -He was notified of both incidents when they occurred. -He thought that facility staff could check in on the residents more often. Interview with a SCU Medication Aide on 7/08/16 at 12:28 pm revealed: -She was not present when the 2/09/16 incident occurred. -She was present for the 4/20/16 incident. -On 4/20/16 she came out of a room after she heard someone calling for staff. -She observed Resident #9 on the floor with blood all over the floor. -She did not think there was staff present to witness the altercation. -Staff provided Resident #9 with towels and pillows and called 911. They took instruction from the 911 dispatcher until the ambulance team arrived. -When Resident #9 returned from the hospital there was no formal monitoring system put in place to increase supervision in efforts to prevent incidents.	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 12 -The staff did take measures to make sure that Resident #9 was not left unattended with the resident (Resident #11) he got in the fight with. Interview with the SCU Resident Care Director on 7/08/16 at 1:05pm revealed: -She was not employed at the facility for either of the altercations. -She would expect that the residents that were involved in the altercation be monitored hourly for 72 hours. -She would expect that staff document the hourly checks. -Any altercation would be diffused immediately and the residents would be redirected. -The incident would then be reported to both of the involved residents responsible parties. -She would report any altercation to the residents physician in the case the physician may order medication changes or laboratory tests. -Increased supervision could include room changes and increased activities. Interview with the Administrator on 7/08/16 at 2:35pm revealed: -She was not employed at this facility during the altercations. -If an altercation occurred she would expect staff to immediately diffuse the situation, separate the residents and provide protection. -After an altercation she would speak with any witnesses and have staff tend to any injuries. -She or staff would notify the responsible parties of the residents involved. -She would evaluate the aggressor and start monitoring checks every 30 minutes to 1 hour for 24 hours. -She would expect that staff document the monitoring checks. -She would report the incident to the local	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 13 Department of Social Services. Interview with the Director of Clinical Services on 7/08/16 12:15 pm revealed: -Resident #9 was originally admitted to the facility on the Assisted Living Unit. When he presented with aggressive behaviors he was moved to the Special Care Unit to increase supervision. -On 2/15/16 Resident #9 was started on Depakote 125 mg sprinkles twice daily in efforts to curb the aggressive behavior. -After the incident on 2/09/16 staff did check on Resident #9 for increased supervision and she provided documentation. -The Activity Director also provided Resident #9 with one-on-one activities and she provided documentation. -On 3/01/16 they moved Resident #9 to a room closer to the nurses station to provide increased supervision. -On 4/29/16 Zoloft (a medication used to treat depression) was added to Resident #9's medication regimen. -On 5/13/16 Resident #9's Zoloft 50mg was increased to 100mg daily and Depakote 125mg twice daily was increased to 250mg three times daily. -On 5/16/16 alprazolam (a medication used to treat anxiety) was changed from .25 mg as needed every 6 hours to. 5mg at bedtime routinely to Resident #9's medication regimen. Review of a sheet of paper with Resident #9's name hand written at the top with no date revealed: -At 3:00 pm Resident #9 was in his room. -At 4:00 pm Resident #9 was in his room. -At 5:00 pm Resident #9 was in the dining room. -At 6:00 pm Resident #9 was in the T.V room. -At 7:00 pm Resident #9 was in his room.	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 14 -At 8:00 pm Resident #9 was in the T.V room. -At 9:00 pm Resident #9 was in his room. -At 10:00 pm Resident #9 was in walking the hall looking for his car. -At 10:30 pm Resident #9 was in his room. -At 11:00 pm Resident #9 was in his room, Good night... Review of a second sheet of paper with Resident #9's name hand written at the top with no date revealed: -At 12:00 am Resident #9 was in his room packing his things. -At 1:00 am Resident #9 was at the desk looking for a moving truck. -At 2:00 am Resident #9 was in his room sleeping. -At 3:00 am Resident #9 was in his room sleeping. -At 4:00 am Resident #9 was in his room sleeping. -At 5:00 am Resident #9 was in his room sleeping. -At 6:00 am Resident #9 was in his room sleeping. -At 7:00 am Resident #9 was in his room sleeping. Review of the Record of One-to-One Activities Form revealed: -On 1/20/16 Resident #9 played checkers with the Activity Director (AD). -On 2/10/16 the AD visited with Resident #9 and he was not feeling well due to the incident on 2/09/16. -On 2/15/16 the AD visited with Resident #9 and looked at the "Can you find it" book. The visit was short due to him not feeling well. -On 2/18/16 they tossed the beach ball and Resident #9 seemed very depressed and	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 15 bothered by recent altercations. -On 2/22/16 they played checkers. -On 2/24/16 they looked and talked about old pictures. -On 2/29/16 they played checkers. -On 3/02/16 they went on a walk. -On 3/09/16 they played checkers and talked. -On 3/23/16 they watched a television show. -On 4/13/ 16 they went on a walk and sat outside. -On 4/27/16 they played checkers and talked. -At the bottom of the form it was documented, "No one-to-one activities the week of 5/01/16 through 5/07/16 due to incident on 4/30/16." -On 5/11/16 they played checkers. -On 5/17/16 they sat outside. -On 5/25/16 they played tic-tac-toe. -On 6/03/16 they watched television and talked. -On 6/07/16 they played checkers and talked. -On 6/16/16 they folded towels. -On 6/23/16 they went for a walk. -On 6/29/16 they played checkers. B. Review of Resident #11's current FL2 dated 01/26/16 revealed: -Diagnoses of dementia and hypercholesterolemia. -An order for Aricept 5 mg (used to treat alzheimer) take 1 tablet at bedtime. -Inappropriate behaviors were documented as wanderer. -Documented level of care was Special Care Unit (SCU). Review of Resident #11's record revealed: -Documentation in the nurse's notes Resident #11 had been in an altercation on 04/30/16 with another Resident in the SCU. -Resident #11 had no injury and family had been notified.	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 16 Review of a police report dated 04/30/16 revealed: -Both residents were in the SCU and had diagnoses of Alzheimer disease. -Resident #11 had walked into the dining room and ran his fingers down the piano keys, this was something he did every morning. -Resident #9 got up from his dining table and came across room and pointed his finger in Resident #11's face and was fussing about the piano. -Resident #11 punched Resident #9 in the face. -Resident #9 lost his balance and fell striking his head on the table. -According to staff Resident #9 is always getting into altercations with other residents. -Resident #11 had never had any problems at the facility. -The case was closed on 04/30/16. Interview on 07/08/16 at 8:20 am with a resident in the SCU revealed: -She had been sitting at the same table as Resident #11 for the breakfast meal. -The staff were getting residents from their room to the dining room. -Resident #11 had walked into the dining rooms' and ran his fingers across the piano keys, like he did every morning. -Resident #9 started cussing at Resident #11 and came across the dining room without using his walker to the table where Resident #11 had been seated. -Resident #9 attempted to hit Resident #11, Resident #11 hit Resident #9 in the chin and Resident #9 lost his balance and fell over hitting his head on the table. -Resident #9 had a large gash to his head and was bleeding.	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 17 -The dietary cook came out and called for help and everyone came running with towels to stop the bleeding. Interview on 07/08/16 at 1:00 pm with the dietary cook revealed: -He had been working on 04/30/16 when the altercation with Resident #11 and Resident #9 occurred. -He had come into the dining room when he heard the residents screaming for help. -Resident #9 was sitting on the floor near Resident #11's table. -Resident #9 was bleeding from his head. -One or two staff had actually seen the altercation. -The staff assisted Resident #9 to lay down and applied towel to stop the bleeding. -Someone called 911 and the police came out too. -Resident #9 had been in several altercations with residents and staff, "He had behavior issues." Interview on 07/08/16 at 12:10 pm with a Personal Care Aide (PCA) in the SCU revealed: -She had not worked on 04/30/16 when the altercation between Resident #11 and Resident #9 happened. -Resident #9 tried to walk without using his walker at times. -Resident #9 was very forgetful. -"We try to keep an eye on him more often and keep him in the common area for closer observation." -Resident #11 had never shown any behaviors issues. Interview on 07/08/16 at 12:25 pm with a second PCA in the SCU revealed: -She had been working on 04/30/16 when the	D 270	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 18 altercation with Resident #9 and Resident #11 had occurred. -She was in a resident's room getting them up and ready for breakfast. -She had been assisting the resident to the dining room area when she heard the residents screaming. -When she arrived in the dining room Resident #9 was sitting on the floor near Resident #11's table, Resident #9's head was bleeding. -She assisted Resident #9 to lay down and applied towels to help stop the bleeding. -That day they had 1 Medication Aide and 4 PCAs working in the SCU. Review of the staffing for the SCU on 04/30/16 revealed they had 1 MA and 4 PCAs working in the SCU for 28 residents. A Plan of Protection was provided by the facility on July 8, 2016 as follows: -Identified residents who are at risk for falls and/or behaviors will be placed on frequent checks for safety. -All care staff will be inserviced on proper documentation and interventions. -The Executive Director, Resident Care Director, Resident Care Coordinator and/or designee will review documentation and determine additional interventions necessary weekly for one month and bi-weekly thereafter. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 7, 2016.	D 270	PLEASE SEE ATTACHED	8/12/16
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 273	Continued From page 19 (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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 8 sampled residents with physician's orders for a psychiatric referral and a urinalysis (Resident #9). The findings are: Review of Resident #9's current FL2 dated 5/30/16 revealed diagnoses included scalp laceration, dementia, aortic stenosis. 1.Review of Resident #9's record revealed: -A physician's order dated 2/10/16 to obtain a psychiatric referral. -A fax cover sheet, insurance information, a copy of the psychiatric referral and consent form signed by the responsible party (RP) dated 5/04/16, with no time or date stamp indicating the paper work had been faxed. Review of Resident #9's Progress Notes revealed: -An entry dated 2/09/16 regarding a physical altercation Resident #9 had with another resident. -Resident #9 was reported to have initiated a fist fight with Resident #11 which Resident #9 sustained a bloody nose. -An entry dated 2/14/16 which documented a bruised left ear and left chin. -An entry dated 2/18/16 which documented	D 273	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 273	Continued From page 20 Resident #9 was agitated and aggressive and was attempting to hit other residents and staff. Resident #9 stated he wanted to burn the facility down and requested matches. -There was no documentation of notifying the family of the psychiatric referral or requesting via fax or phone a psychiatric referral. -There was no documentation for the month of March 2016. Further Review of Review of Resident #9's Progress Notes revealed: -An entry dated 4/30/16 documenting Resident #9 was involved in an altercation with another resident which caused Resident #9 to fall and sustained a laceration to his head. -Resident #9 was sent to the local hospital emergency room and returned with 27 staples in his head. Review of Resident #9's Physician's Visit Summary dated 5/10/16 revealed Resident #9 sustained a head injury with large laceration which required 27 staples. Interview with the contracted Psychiatric Agency Representative on 7/07/16 at 12:16 pm revealed: -The consent for Resident #9 was dated 5/05/16 and entered into the system the same day. -It took 4 days for the insurance to process and approve the referral. -The initial visit with Resident #9 was on 5/09/16 but this was not with a psychiatrist. -Resident #9's first visit from the psychiatrist was 5/16/16. Interview with the Responsible Party on 7/07/16 at 6:00 pm revealed: -The facility notified him of the psychiatric referral but he did not know exactly when he was first	D 273	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 273	Continued From page 21 notified. -From the time of the notification it was approximately 3-4 weeks before he signed the consent for the contracted psychiatric agency. -At first they wanted to get Resident #9 in to see a psychiatric physician at the Veteran's Administration. -"We made the decision to use the facility's the contracted psychiatric agency because it was quicker to have him seen and this was the reason for the delay." -He thought he was notified about the referral in April 2016, but did not know exactly when. -He knew he was not told of the referral in February 2016. Interview with a SCU Medication Aide on 7/08/16 at 12:32 pm revealed: -Referrals to outside agencies such as a psychiatric physician were faxed to the appropriate agency and documented in the resident record. -She did not initiate the psychiatric referral for Resident #9 and did not know if it was faxed. -She was aware of both physical altercations that involved Resident #9 and his tendency to be aggressive and agitated at times. -She did not know why the referral took a long time to initiate the psychiatric referral. Interview with a Representative from the Veteran's Administration revealed: -He reviewed one year's worth of telephone messages which included messages from the family and previous caregiver, the home health agency and the facility. -The was no documentation of any message left in regards to requesting an appointment with a psychiatric physician or in reference to the	D 273	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 273	Continued From page 22 psychiatric referral ordered on 2/10/16. Interview with the Resident Care Director on 7/08/16 at 12:56 pm revealed: -She was not employed at this facility when Resident #9's referral was ordered by Resident #9's physician. -She was not aware that it took from 2/10/16 to 5/16/16 to have the referral initated and did not know why it took this long. -She expected referrals be initiated the same day they were ordered by the practitioner. Interview with the Director of Clinical Services on 7/08/16 at 12:15 pm: -She did not know why the referral took from 2/10/16 to 5/16/16 to be initiated. -She did expect staff to initiate referrals upon receipt. Attempted interview with Resident #9's Psychiatrist on 7/08/16 at 11:35 am was unsuccessful. 2. Review of Resident #9's record revealed a physician's order dated 6/03/16 to obtain a urinalysis with culture and sensitivity (U/A C&S). Review of Resident #9's Nurses Notes revealed: -On 6/03/16 it was documented Resident #9 received a new order for a U/A C&S and to call the laboratory when specimen was ready. -There was no documentation that the specimen was obtained, sent to the lab and the results were received by the facility or reviewed by the physician. Interview with a SCU Medication Aide (MA) on 7/08/16 at 12:29 pm revealed: -She did not know about Resident #9's order to	D 273	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 273	Continued From page 23 obtain a U/A C&S and did not know if a specimen was obtained or sent to the laboratory. -The Personal Care Aides (PCAs), and MAs were responsible for obtaining specimens and calling the laboratory. -If there was a U/A C&S ordered the MAs and PCAs would report the order on their staff turn over report. -Sometimes laboratory test were also entered on to the Medication Administration Record when they were due. -PCAs, MAs and home health were responsible for obtaining laboratory specimens. -She did not think there was any formal process to reflect if ordered laboratory work was completed and reviewed by the physician. Interview with the Director of Clinical Operations on 7/08/16 at 12:18 pm revealed: -They did not obtain a U/A C&S on Resident #9 because he went to the hospital during that time and they most likely checked his urine at the hospital. -The new FL2 did not order a U/A C&S and therefore staff did not have to execute the physician orders prior to the hospitalization. Review of Resident #9's record revealed that there was no documentation of a hospitalization in June 2016. A Plan of Protection was provided by the facility on July 8, 2016 as follows: -All medication aides will be inserviced to utilize the new order tracking for all new orders and treatments including labs. -Completed a three way check by outside provider and will follow up to ensure all orders have been initiated. -The Executive Director, Resident Care Director	D 273	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 273	Continued From page 24 and the Resident Care Coordinator and/or designee will review and audit all new order tracking to ensure accuracy and implementation. -If unable to collect a laboratory specimen will notify ordering Primary Care Provider. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 22, 2016.	D 273	PLEASE SEE ATTACHED	8/12/16
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to assure implementation of orders for a resident who required dressing changes to a suprapubic catheter four times a day and for failure to implement orders for a surgical procedure for 1 of 7 sampled residents (Resident #1). The findings are: Review of Resident #1's record and current FL-2 dated 3/18/16 revealed:	D 276	PLEASE SEE ATTACHED Addendum made in poc to this tag per telephone conversation 8.18.16 11:23 am. LK	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 276	Continued From page 25 -Diagnoses included syncope, dehydration, foley catheter, dementia, dyslipidemia, and a history of cerebral vascular disease. -He was constantly disoriented. -Resident #1 had an insertion of a suprapubic catheter on 4/18/16. 1. Review of Resident #1's Care Plan dated 4/26/16 revealed. -He was totally dependent upon staff for toileting, bathing, dressings, and grooming. -He was ambulatory with the use of a walker. Review of Resident #1's record revealed: -Resident #1 was seen by the urologist on 6/02/16. -He received new orders on 6/02/16 for Diflucan 200mg (used to treat and prevent fungal infections) 1 tablet every day for 5-days, Keflex 500mg (used to treat infections caused by bacteria) 1 tablet 3-times a day for 7-days, and to change the SPC dressing 4-times per day. -Resident #1 received an order on 6/23/16 to apply Clotrimazole Cream 1% to affected area for two weeks (an anti-fungal medication used to treat yeast infections). Observation of Resident #1 on 6/16/16 at 1:08 PM revealed: -Resident #1 was sitting in a recliner in his room reading a paper with the television on. -Resident #1 gave the Medication Aide, (MA), permission to look at his supra pubic catheter. -Resident #1 had a red yeasty looking rash around the suprapubic catheter (SPC) about the size of a fist. -There was no tape or dry dressing around the site. Interview with the MA on 6/16/16 at 1:08 PM	D 276	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 276	Continued From page 26 revealed: -She was the MA who administered medication to Resident #1 and changed his SPC dressings. -She cleaned Resident #1's rash with Peroxide. -She did not know why she cleansed Resident #1's SPC area with Peroxide without an order. MA reported she thought she was doing the right thing. -No one told her to clean Resident #1's SPC with the Peroxide. Interview with Resident Care Director, RCD on 7/08/16 at 11:58 AM reported: -A MA came to her on 6/1/16 to look at Resident #1's SPC area. -The RCD contacted the urologist about seeing Resident #1 for a possible infection. -The RCD notified Resident #1's responsible party and informed her about Resident #1 needing to be seen for a possible infection around the SPC area. -The Responsible Party told the RCD she would provide transportation to the appointment. -RCD stated Resident #1 was seen the next day. -Resident #1 returned from the appointment with new orders. -The MAs were trained by return demonstration to clean Resident #1's SPC area with soap and water, pat the area dry, and to place dry gauze around SPC to ensure the area stay dry to prevent infection. Review of the June 2016 Medication Administration Record (MAR) revealed: -Documentation staff initialed 30-days in June that Resident #1's SPC was cleansed with soap and water and dry dressing was applied every day. -On 6/2/16, a handwritten order to "change the SPC dressing 4-times per day and to please	D 276	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 276	Continued From page 27 avoid tape" was added to the MAR. -The dressing change were documented as beginning completed 3 times daily from 6/02/16 through 6/12/16 -Documentation for SPC dressing changes was written on 6/13/16 that Resident #1 received the ordered dressing change 4 times per day from June 13 until June 30. 2. Review of Resident #1's record on 7/07/16 revealed: -Resident #1 was scheduled to have a new SPC inserted on 4/13/16. -The facility had received specific instructions from the hospital to stop Certavite (a medication used to treat or prevent vitamin deficiencies), Vitamin B1 (a medication used to treat thiamine deficiency), and Vitamin D3 (a medication used to aid the absorption of calcium from the stomach and for the functioning of calcium in the body) on 4/09/16. -The facility had received instructions for Resident #1 not to eat or drink after midnight on 4/12/16 and not to apply the Nystatin Cream (a medication used to treat skin infections caused by yeast) around the stoma site on 4/13/13. -There was no documentation in Resident #1's record to reflect his surgical procedure needed to be postponed due to Resident #1 eating breakfast the morning of his surgical procedure and not stopping his medications in a timely manner. Interview with the Resident Care Director (RCD) on 7/08/16 at 11:58 AM revealed: -She was not working at the facility during the time Resident #1's surgical procedure had to be rescheduled because the MA allowed Resident #1's to eat breakfast and his medications were not stopped timely.	D 276	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 276	Continued From page 28 Review of the April 2016 Medication Administration Record (MAR) revealed: -Resident #1's MAR documented holding his Certavite, Vitamin B1, and Vitamin D3 as ordered on 4/11, 4/12 and 4/13/16. -Resident #1 received the Certavite, Vitamin B1, and Vitamin D3 on 4/09 and 4/10/16 despite the order to hold these medications. -The Certavite, Vitamin B1 and Vitamin D3 were held on 4/16, 4/17 and 4/18/16 without an order. Interview with a Registered Nurse (RN) from Resident #1's physician office on 7/08/16 at 3:40 PM revealed: -Resident #1 had the SPC inserted on 4/20/16. -RN stated that any medications to hold or administer would come from the hospital and not their office. -She was not able to get into the records to see why the procedure was rescheduled. -She did no see anything in the files she had access to at this time. -The RN did not provide any information about the care Resident #1 received at the facility. Interview with Assisted Living Resident Care Coordinator (RCC) on 7/08/16 at 2:45 PM revealed: -The previous RCD did not document any information on Resident #1's record about the surgical procedure being rescheduled. -Staff failed to report information concerning the procedure in the shift change notes. -The previous RCD had taken a telephone order from the hospital to hold medications for the new surgery date, but failed to document the information in Resident #1's record. Telephone interview with Resident #1's	D 276	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 276	Continued From page 29 Responsible Party (RP) revealed: -The RP moved Resident #1 out of the facility on 6/30/16 due to the lack of care he received at the facility. -She had to reschedule Resident #1's surgical procedure because the facility fed him breakfast and did not stop his medications in a timely manner. -When she attempted to voice her concerns about Resident #1's care, the management, and regional management would try to make everything seem like it was her fault. -The doctor would voice concerns that Resident #1 was not being cared for during his appointments. -Resident #1's rash was getting worst at the facility because staff was not caring for the rash properly. -Resident #1 was no longer residing in the facility to provide additional information. A Plan of Protection was provided by the facility on July 8, 2016 as follows: -All medication aides will be inserviced to utilize the new order tracking for all new orders and treatments including labs. -Completed a three way check by outside provider and will follow up to ensure all orders have been initiated. -The Executive Director, Resident Care Director and the Resident Care Coordinator and/or designee will review and audit daily all new order tracking to ensure accuracy and implementation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 7, 2016.	D 276	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 344	Continued From page 30	D 344	PLEASE SEE ATTACHED	8/12/16
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's physician for clarification of orders which were not dated and signed within 24 hours of admission to the facility for 1 of 8 sampled residents (Residents #9). The findings are: A. Review of Resident #9's current FL2 dated 5/30/16 revealed: -Diagnoses included scalp laceration, dementia, aortic stenosis, hyperlipidemia, osteoporosis, glaucoma, history of prostate cancer and chronic left lower extremity skin ulcers secondary to skin burns. -Physician orders for clotrimazole 1% topical cream one application to skin twice daily (a medication used to treat fungal infections), fluconazole 100mg one tablet daily (a medication	D 344	Addendums made on POC to this tag per telephone conversation 8.18.16 11:23 am. LB	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 344	Continued From page 31 used to treat and prevent fungal infections), simvastatin 80mg one tablet each night (a medication used to treat high cholesterol and triglyceride levels). Review of Resident #9's record revealed: -A physicians order dated 5/17/16 for clotrimazole 1% apply to face twice daily for 14 days. -A physicians order dated 5/27/16 for fluconazole 100mg 1 tablet twice daily for 14 days. -A physicians order dated 6/21/16 for fluconazole 100mg 1 tablet daily for 6 days. Review of Resident #9's Medication Reconciliation for Transfer Form, hand signed and dated 5/30/16 revealed: -A physician's order for fluconazole 100mg 1 tablet daily. -A physician's order for simvastatin 40mg 1 tablet every evening. -There was no physician's order for clotrimazole 1% topical cream. -A physician order for docusate-senna 1 tablet daily. Review of Resident #9's May 2016 Medication Administration Record (MAR) revealed: -An entry for clotrimazole 1% cream to be applied to face twice a day for 14 days and documented as administered at 8:00 am and 8:00 pm from 5/18/16 through 5/28/16 and 5/31/16, at 8:00 am on 5/29/16 and leave of absence (LOA) documented from 5/29/16 8:00 pm and 8:00 am 5/30/16. -An entry for fluconazole 100mg one tablet once daily for 14 days documented as administered at 8:00 am 5/28, 5/29 and 5/31/16. -A Leave of Absence (LOA) was documented for 5/30/16. -An entry for simvastatin 80mg - 1/2 tabs (40mg)	D 344	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 344	Continued From page 32 every evening and documented as administered 5/01/16 through 5/31/16 at 8:00 pm except on 5/29/16 which LOA was documented. -There was no entry for docusate-senna. Review of Resident #9's June 2016 MAR revealed: -An entry for clotrimazole 1% cream apply to face bid x 14 days and documented as administered 6/01/16, no time noted, and a hand written stop in the hour column with no date indicated. -An entry for fluconazole 100mg tablet 1 tablet daily and documented as administered at 9:00 am from 6/18/16 though 6/27/16 with a hand written stop dated 6/28/16. -An entry for simvastatin 80mg 1/2 tab (40mg) every evening and documented as administered 6/01/16 through 6/30/16 at 8:00 pm. Review of Resident #9's record revealed Resident #9 was admitted to the hospital for a fall with a scalp laceration on 5/29/16 and discharged back to the facility on 5/30/16. Review of Resident #9's electronically signed hospital discharge summary dated 5/30/16 revealed: -A physician's order for clotrimazole 1% topical cream 1 application twice daily. -A physician's order for fluconazole 100mg 1 tablet daily. -A physician's order for simvastatin 80mg 1 tablet every evening. Resident #9 was in the hospital and not available for interview. Interview with a Medication Aide (MA) on 7/08/16 at 12:25 pm revealed: -Residents were typically admitted with either a	D 344	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 344	Continued From page 33 signed hospital discharge summary or FL2. -If they had both a signed hospital discharge summary and FL2 they were expected to call the primary care physician for clarification within 72 hours. -She was not at the facility when Resident #9 was re-admitted to the facility from the hospital. -The Resident Care Director would process all admissions and re-admissions if she was at the facility and the MAs were expected to do so in her absence. Interview with the Special care Unit (SCU)Resident Care Director (RCD) on 7/08/16 at 12:56 pm revealed: -The residents were usually admitted back to the facility on first or second shift and she would be present for these admissions. -She or the Assisted Living Unit (ALU)Resident Care Coordinator (RCC) would review the admission paper work prior to the re-admission. -They would process the orders by transcribing them, faxing to the pharmacy, documenting and if there was a discrepancy between an FL2 and a hospital discharge summary they would contact the physician the same day to obtain clarification. -If the RCD or RCC were not present for the re-admission then two MAs were expected to check behind each other to make sure the orders were processed accurately. -The MAs were expected to call the physician if clarification was required. -The RCD and/or RCC were expected to go behind the MAs to ensure orders were clear and ensure accuracy of all order entries. -The RCD or the RCC were not employed at this facility when Resident #9 was re-admitted from the hospital and were not aware that there were differences between the FL2, discharge summary and the Medication Reconciliation for Transfer	D 344	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 344	Continued From page 34 Form. Interview with the Administrator on 7/08/16 at 2:29 pm revelaed: -She expected the RCD and/or RCC to clarify all admission and/or re-admission orders. -If the RCD or RCC were not present the MAs were permitted to process admission orders. -The clarification of orders was to occur on the day of admission or at least within 24 hours of the admission/re-admission. -She was not aware that there were differences between the FL2, hospital discharge summary and the Medication Reconciliation for Transfer Form.	D 344	PLEASE SEE ATTACHED	8/12/16
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 ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 7 sampled residents with orders for clotrimazole, fluconazole and simvastatin (Resident #9). Review of Resident #9's current FL2 dated 5/30/16 revealed:	D 358	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 358	Continued From page 35 -Diagnoses included scalp laceration, dementia, aortic stenosis, hyperlipidemia, and chronic left lower extremity skin ulcers secondary to skin burns. -Physician orders for clotrimazole 1% topical cream one application to skin twice daily (a medication used to treat fungal infections), fluconazole 100mg one tablet daily (a medication used to treat and prevent fungal infections), simvastatin 80mg one tablet each night (a medication used to treat high cholesterol and triglyceride levels). Review of Resident #9's record revealed a physicians order dated 6/21/16 for fluconazole 100mg 1 tablet daily for 6 days. Review of Resident #9's electronically signed hospital discharge summary dated 5/30/16 revealed: -A physician's order for clotrimazole 1% topical cream 1 application twice daily. -A physician's order for fluconazole 100 mg 1 tablet daily. -A physician's order for simvastatin 80mg 1 tablet every evening. Review of Resident #9's Medication Reconciliation for Transfer Form, hand signed and dated 5/30/16 revealed: -A physician's order for fluconazole 100mg 1 tablet daily. -A physician's order for simvastatin 40mg 1 tablet every evening. -There was no physician's order for clotrimazole 1% topical cream. -A physician order for docusate-senna 1 tablet daily. Review of Resident #9's May 2016 Medication	D 358	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 358	Continued From page 36 Administration Record (MAR) revealed: -An entry for clotrimazole 1% cream to be applied to face twice a day for 14 days and documented as administered at 8:00 am and 8:00 pm from 5/18/16 through 5/28/16 and 5/31/16, at 8:00 am on 5/29/16 and leave of absence (LOA) documented from 5/29/16 8:00 pm and 8:00 am 5/30/16. -An entry for fluconazole 100mg one tablet once daily for 14 days documented as administered at 8:00 am 5/28, 5/29 and 5/31/16. - A Leave of Absence was LOA documented for 5/30/16. -An entry for simvastatin 80mg - 1/2 tabs (40mg) every evening and documented as administered 5/01/16 through 5/31/16 at 8:00 pm except on 5/29/16 which LOA was documented. -There was no entry for docusate-senna. Review of Resident #9's June 2016 MAR revealed: -An entry for clotrimazole 1% cream apply to face bid x 14 days and documented as administered 5/01/16, no time noted, and a hand written stop in the hour column with no date indicated. -An entry for fluconazole 100 mg tablet 1 tablet daily and documented as administered at 9:00 am from 6/18/16 though 6/27/16 with a hand written stop dated 6/28/16. -An entry for simvastatin 80mg - 1/2 tabs (40mg) every evening and documented as administered 6/01/16 through 6/30/16 at 8:00 pm. -There was no entry for docusate-senna. Review of Resident #9's record revealed Resident #9 was admitted to the hospital for a fall with a scalp laceration on 5/29/16 and discharged back to the facility on 5/30/16. Observation of Resident #9's medication on hand	D 358	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 358	Continued From page 37 revealed: -There were medications that were in bottles from an outside pharmacy as well as medications that were on cards filled by the contracted pharmacy. -A partially used 30 gram tube of clotrimazole ointment, one card of simvastatin 80mg with 12 half tablets (40mg) and one card of fluconazole with 6 tablets remaining. -There were no docusate-senna tablets. Interview with a Medication Aide (MA) on 7/08/16 at 12:30 pm revealed: -Residents were typically admitted with either a signed discharge summary or FL2. -She was not at the facility when Resident #9 was re-admitted to the facility from the hospital. -She did not recall Resident #9 taking senna-s when he returned from the hospital. -Resident #9 had been on fluconazole and clotrimazole several different times but did not know if they were being administered prior to his going to the hospital 7/02/16. -She administered medications according to the MAR and did not check the MAR against the admission orders from the hospital. Interview with a representative from the contracted pharmacy on 7/08/16 at 2:45 pm revealed: -They did not fill docusate-senna for Resident #9. -They filled clotrimazole 1% cream on 5/17/16, 6 tablets of fluconazole 100 mg on 6/21/16 and 30 tablets of simvastatin 80mg 1/2 tablets (40mg) on 6/14/16. -They did not have an order for simvastatin 80mg. -Resident #9 obtained his medications through their pharmacy but also used the Veteran's Administration's pharmacy and it was possible that medications were filled at the other pharmacy.	D 358	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 358	Continued From page 38 Interview with the Resident Care Director (RCD) on 7/08/16 at 12:56 pm revealed: -The RCD or the RCC were not employed at this facility when Resident #9 was re-admitted from the hospital and were not aware there were differences between the FL2, hospital discharge summary and the Medication Reconciliation for Transfer Form. -They would process the orders by transcribing them, faxing to the pharmacy, documenting and if there was a discrepancy between an FL2 and a hospital discharge summary they would contact the physician the same day to obtain clarification. -Once clarification was received by the physician and the orders confirmed she would transcribe them and have the RCC check the MARs for accuracy. -The MAs were expected to call the physician if clarification was required. -The RCD and/or RCC were expected to go behind the MAs to ensure orders were clear and ensure accuracy of all order entries. Interview with Resident #9's Primary Care Physican on 7/08/16 at 12:25 pm revealed that he was new to the facility and he had only seen Resident #9 once. -He would not be able to comment on Resident #9's medications at that time. Resident #9 was in the hospital and not available for interview.	D 358	PLEASE SEE ATTACHED	8/12/16
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 364	Continued From page 39 administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to assure administration of medications within one hour before or one hour after the prescribed or scheduled time for 5 of 7 residents (Residents #16, #15, #11, #12, and #14). The findings are: Observation on 07/06/16 at 6:00 pm during the initial tour revealed: -There were 23 residents in the Special Care Unit (SCU). -The SCU had 1 Medication Aide (MA) working on 07/06/16. -There were two medication carts located in the SCU. -Each medication cart had a Medication Administration Record (MAR)three ring binder book located on the top of the carts. Review on 07/06/16 at 6:00 pm of the MAR book for the SCU located on a medication cart revealed: -The facility used pharmacy generated MARs for all the residents. -Medications scheduled for 8:00 pm and 9:00 pm had been initialed as administered on 07/06/16 to 5 of 23 residents in the SCU. A. Review of Resident #16's current FL2 dated 05/26/15 revealed diagnoses that included dementia. Review on 07/06/16 at 6:05 pm of Resident #16's	D 364	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 364	Continued From page 40 MAR for July 2016 revealed: -An entry for Melatonin 30 mg (a hormone used for sleep) take 2 tablets at bedtime scheduled for 9:00 pm had been initialed on 07/06/16 as administered. -An entry for Depakote (used for a mood stabilizer) 125 mg take two times daily scheduled for 2:00 pm and 9:00 pm had been initialed as administered on 07/06/16 for 9:00 pm. -An entry for Buspar 10 mg take 1 tablet two times daily scheduled for 2:00 pm and 9:00 pm was initialed as administered on 07/06/16 for 9:00 pm. -An entry for tripleptal 150 mg take 1 tablet two times daily scheduled for 9:00 am and 9:00 pm was initialed as administered on 07/06/16 for 9:00 pm. Refer to interview on 07/06/16 at 7:00 pm with the Medication Aide (MA). Refer to interview on 07/06/16 at 9:30 pm with the Resident Care Director. Refer to interview on 07/06/16 at 9:50 am and on 07/08/16 at 9:35 am with the facility Registered Nurse consultant. Refer to interview on 07/08/16 at 12:25 pm with the facility Physican Assistant (PA). B. Review of Resident #15's current FL2 dated 04/02/16 revealed diagnoses that included dementia. Review on 07/06/16 at 6:08 pm of Resident #15's MAR for July 2016 revealed: -An entry for Neurontin (nerve pain medication) 400 mg take 1 tablet three times daily scheduled for 8:00 am, 2:00 pm and 8:00 pm were initialed	D 364	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 364	Continued From page 41 as administered on 07/06/16 for 8:00 pm. -An entry for potassium chloride (used for low potassium levels) 20 meq take three times daily scheduled for 8:00 am, 2:00 pm and 8:00 pm was initialed as administered on 07/06/16 for 8:00 pm. -An entry for calcium carbonate (used as an antacid) 600 mg take 1 tablet two times daily scheduled for 12:00 pm and 8:00 pm were initialed as administered on 07/06/16 for 8:00 pm. Refer to interview on 07/06/16 at 7:00 pm with the Medication Aide (MA). Refer to interview on 07/06/16 at 9:30 pm with the Resident Care Director. Refer to interview on 07/06/16 at 9: 50 am and on 07/08/16 at 9:35 am with the facility Registered Nurse consultant. Refer to interview on 07/08/16 at 12:25 pm with the facility Physican Assistant (PA). C. Review of Resident #12's current FL2 dated 12/4/15 revealed diagnoses that included Alzheimer, dementia, and hypertension. Review on 07/06/16 at 6:12 pm of Resident #12's MAR for July 2016 revealed: -An entry for Ambien (a sedative for sleep) 5 mg take 1 tablet at bedtime scheduled for 8:00 pm had been initialed as administered. -An entry for Atenolol (used for high blood pressure) 50 mg take 1 tablet at bedtime scheduled for 9:00 pm had been initialed as administered. -An entry for Aricept (used for cognition enhancing) 10 mg take 1 tablet at bedtime scheduled 9:00 pm had been initialed as administered.	D 364	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 364	Continued From page 42 -An entry for Baza (antifungal) cream apply two times daily scheduled for 9:00 am and 9:00 pm had been initialed as administered for 9:00 pm. Review of the narcotic control substance medication record for Resident #12 revealed Ambien 5 mg tablets had 4 remaining as of 07/05/16 at the ending count. Observation on 07/06/16 at 6:12 pm of medications on hands for Resident #12 revealed a bubble pack of Ambien 5mg with a remaining count of 4. Interview on 07/06/16 at 7:00 pm with the second shift MA revealed: -He had worked as a MA in the facility for about 6 months. -He had given Resident #12 his bedtime medications early at 6:00 pm on 07/06/16. -He had not informed management or the Resident Care Director he had given Ambien 5 mg early for the last 2 months to Resident #12 in the SCU. -He had given Ambien 5mg early because the family of Resident # 12 had requested it. -He had administered Resident #12's Ambien 5 mg at 6: 00 pm on 07/06/16, but could not recall signing the Ambien 5 mg out on the narcotic control record. -He had contacted the physician to get the Ambien 5 mg changed to 6:00 pm, but had not documented the conversation or the attempt to call. Interview on 07/08/16 at 8:20 am with Resident #12 family member revealed: -She and Resident #12 shared a room in the SCU. -She was aware of the medications Resident #12	D 364	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 364	Continued From page 43 had taken. -She relied on the MAs to administer medications to Resident #12. -Resident #12 took his night medications at the dining room table while he was eating the dinner meal. -"The staff assisted Resident #12 back to his room after dinner and placed him in a recliner chair in front of the television." -She was aware Resident #12 was administered a sleeping pill at dinner, but preferred to have it administered later due to his waking up early in the morning hours and not going back to sleep. Refer to interview on 07/06/16 at 7:00 pm with the Medication Aide (MA). Refer to interview on 07/06/16 at 9:30 pm with the Resident Care Director. Refer to interview on 07/06/16 at 9: 50 am and on 07/08/16 at 9:35 am with the facility Registered Nurse consultant. Refer to interview on 07/08/16 at 12:25 pm with the facility Physican Assistant (PA). D. Review of Resident #14's current FL2 dated 05/02/16 revealed diagnoses that included dementia. Review on 07/06/16 at 6:13 pm of Resident #14's MAR for July 2016 revealed: -An entry for Ambien 5 mg scheduled medication to be administered at 8:00 pm. -Documentation on 07/05/16 Ambien 5 mg had been administered at 8:00 pm. -No documentation Ambien 5 mg had been administered on 07/06/16.	D 364	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 364	Continued From page 44 Review of the narcotic control substance medication record revealed an ending count on 07/05/16 Ambien 5mg were 22. Interview on 07/06/16 at 7:00 pm with the second shift MA revealed: -He had given Resident #14's Ambien 5mg early at 6:00 pm on 07/06/16. -He had signed out the Ambien 5mg for Resident #14 and had administered the Ambien 5 mg, but had not signed the Ambien 5 mg out on the narcotic control record. Review of Resident # 14's medications on hand for Ambien 5mg revealed a bubble pack with a count of 21. Refer to interview on 07/06/16 at 7:00 pm with the MA. Refer to interview on 07/06/16 at 9:30 pm with the Resident Care Director. Refer to interview on 07/06/16 at 9: 50 am with the facility Registered Nurse consultant. Refer to interview on 07/08/16 at 12:25 pm with the facility Physican Assistant (PA). _____ Interview on 07/06/16 at 7:00 pm with the second shift MA revealed: -He had worked as a MA in the facility for about 6 months. -He had given Residents' in the SCU their bedtime medications early at 6:00 pm on 07/06/16. -He had not informed management or the Resident Care Director he had given the bedtime medication early for the last 2 months to residents	D 364	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 364	Continued From page 45 in the SCU. -He was aware of the one hour before and one hour after time frame he had to administer the medications to the residents in the SCU. Interview on 07/06/16 at 9:30 pm with the Resident Care Director revealed: -She had been employed at the facility for 6 weeks and had been in the SCU for 3 weeks. -She was responsible for the nursing staff in the SCU. -She was not aware the MA was administering the bedtime medications at 6:00 pm. -It was the policy to give the medications one hour before or one hour after the scheduled time. -She was not aware if the MA had contacted the family or the physician to change the times of the bedtime medications. -She relied on the MA to give the medications to the residents in the SCU at the appropriate time it had been scheduled. Interview on 07/06/16 at 9:50 am and on 07/08/16 at 9:35 am with the facility Registered Nurse consultant revealed: -She conducted the training for all new MAs prior to them passing medications. -She completed the medication check off list for all new MAs prior to them administering medications. She was aware of the policy to give the medications one hour before or one hour after the scheduled time. -She had instructed the MAs to follow this procedure. Interview on 07/08/16 at 12:25 pm with the facility Physican Assistant (PA)revealed: -He was new to the facility. -He was not aware Ambien was given at 6:00 pm	D 364	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 364	Continued From page 46 to the residents when it had been scheduled for 8:00 pm. -Ambien would take about 30 minutes to take effect. -He thought the resident should be in bed when he took the Ambien to prevent falls. -The faciliy had contacted him on 07/07/16 to either discontinue the Ambien or make it as needed for a resident. -He expected the facility to follow the orders and administer the medications to the resident in the appropriate scheduled time.	D 364	PLEASE SEE ATTACHED	8/12/16
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observation, record review, and interviews the facility failed to assure medications were administered to 1 of 5 residents (Resident # 17) observed on a medication pass in accordance with infection control measures. The findings are: Observation of an evening medication pass on 7/6/16 at 7:55 pm revealed: -The Medication Aide (MA) cleansed his hands with a hand sanitizer located on the medication cart prior to administering medications to	D 371	PLEASE SEE ATTACHED 8/12/16 Addendum made on POC to this tag per telephone conversation 8.18.16 11:23 am.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 371	Continued From page 47 Resident #17. -The MA popped each of Resident #17's oral medications from a bubble pack, placed them into a medicine cup, and administered medications with sips of water to Resident #17. -The MA ask Resident #17 to tilt his head back and the MA used his left index finger to hold the bottom eye lid down. -The MA then placed one drop of Travatan 0.004% eye drops into each of Resident #17 eyes without applying gloves. Observation on 7/6/16 at 8:00 pm of the medication cart revealed a box of gloves were on the medication cart. Interview on 7/7/16 at 4:20 pm with the MA revealed: -He had worked as a MA in the facility for about 6 months. -He was aware the facility's policy was to wear gloves when administering eye drops. -He had not used gloves on 7/6/16 to administer eye drops to Resident #17 due to Resident #17 "becomes agitated" when he had worn gloves. -"Resident #17 does not like it when I wear gloves." Interview on 7/8/16 at 9:35 am with the facility Registered Nurse Consultant revealed: -She conducted the training for all new MAs prior to them passing medications. -She completed the medication check off list for all new MAs prior to them administering medications. -She trained the MAs on the administration of eye drops prior to them administering eye drops to the residents. -She had trained the MAs to apply gloves for universal precautions when applying eye drops.	D 371	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 371	Continued From page 48 Review of the facility's infection control policy revealed gloves should be worn during any procedure that involves potential exposure to blood or body fluids.	D 371	PLEASE SEE ATTACHED	8/12/16
D 397	10A NCAC 13F .1008 (f) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (f) Controlled substances that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored securely in a locked area separately from actively used medications until disposed of. This Rule is not met as evidenced by: Based on observation, record reviews, interviews, and review of policies and procedures, the facility failed to assure discontinued controlled substances were stored securely in a locked area separately from actively used medications until disposed of, which resulted in 24 tablets of Oxycodone missing for 1 of 1 sampled resident. (Resident #3): The findings are: Review of Resident #3's FL-2 dated 4/12/16 revealed diagnoses included Parkinson's disease with dementia, insulin-dependent diabetes with a history of non-compliance, hypertension, dyslipidemia, reflux and hyperlipidemia. Observation on 6/3/16 at 6:15 PM of the facility's medication administration carts in the Special Care Unit (SCU) revealed:	D 397	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 397	Continued From page 49 -The facility had 2 medication carts for the residents medications in the SCU. -Both medication carts were locked. -The medication carts contained a separate locked drawer for controlled medications. Observation of Resident #3 on 6/3/16 at 6:45 pm revealed: -Resident #3 was lying in bed with his eyes closed and mouth wide opened with labored breathing. -Resident #3 had both family members at his bedside. -There were no observed medications in Resident #3's room. Interview with Resident #3's family members on 6/03/16 at 6:45 pm revealed: -Resident #3 was under Hospice Care. -Resident #3 was unable to swallow pills or eat food. -Resident #3 was ordered Roxanol 5mg/.25 ml (a schedule II opioid narcotic used for moderate to severe pain) under the tongue on 6/02/15. Review of Resident #3's record revealed Resident #3 was admitted to Hospice services on 5/26/16. Review of facility documentation revealed the following missing controlled drugs: -On 6/03/16 Resident #3 had 11 tablets of Oxycodone 5mg missing and the facility had reported this to the police, pharmacy, and Health Care Personnel Registry (HCPR). -On 6/03/16 Resident #3 had 13 tablets of Oxycodone 5mg missing and the facility had reported this to the police, pharmacy, and HCPR.	D 397	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 397	Continued From page 50 Interview with the Administrator on 6/03/16 at 7:15 PM reported: -The facility had reported Resident #3's missing Oxycodone to the police department and the pharmacy. -The police came to the facility and took a report on 6/03/16. -Facility staff and department directors conducted a search of the Special Care Unit (SCU) rooms and residents' belongings to look for the missing medications. -Each staff working in the SCU voluntarily allowed the Administrator to check their bags, personal belongings, and cars for the missing medication. -The medications were never located. Interview on 6/16/16 at 11:28 am with the first shift Medication Aide (MA)in the SCU revealed: -She reported to work at the facility around 7:30 am on 6/03/16 in the SCU. -She counted off the medication cart with the SCU Resident Care Director (RCD) at the beginning of her shift on 6/03/16. -The RCD pulled Resident #3's discontinued medications from the Medication Cart and placed the medications in the medication room. -The RCD told the MA to fill out the paperwork and send the discontinued medications for Resident #3 back to the pharmacy. -After she filled out the required paperwork, she took the forms and wrapped the forms around the medications that needed to be sent back to the pharmacy with a rubber band. -She then requested another staff person to count behind her to verify the number of medications being returned to the pharmacy. -The staff member was busy with breakfast and could not assist with the medication count. -She placed the medication cards with the forms	D 397	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 397	Continued From page 51 wrapped in a rubber band in the pharmacy tote under the nurses' station desk without locking the tote. -According to the MA, the pharmacy tote cannot be locked until the pills were counted and the paperwork was completed to go inside the tote along with the returned medications. The pharmacy tote could only be unlocked by the pharmacy. -When the Wellness Director (WD) came into the SCU on 6/03/16 around 11:30 am, she requested the WD to count the medications with her. -The pharmacy tote was still under the desk when the MA and WD attempted to verify all medications being sent back to the pharmacy. -MA and WD discovered that two cards of Resident #3's Oxycodone were missing. -One of the missing cards had 11 pills of Oxycodone 5mg and the other missing card had 13 pills of Oxycodone 5mg. -She and the WD immediately reported the missing medications to the Administrator. -Facility staff working on 6/03/16 voluntarily had their bags, personal belongings, and cars searched for the missing medications. -The Administrator and department heads searched for the missing medication in residents' rooms and belongings. -She understood that the person who pulled the medications from the medication cart was responsible for completing the paperwork to send the medication back to the pharmacy. -Once the medication was verified by two people, the medications were placed in the pharmacy tote and locked with a red lock. -Only the pharmacy had a key to unlock the pharmacy tote. -The missing Oxycodone was never located. Interview with SCU RCD on 7/07/16 at 3:40 pm	D 397	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 397	Continued From page 52 revealed: -She was the person who pulled the medications with the MA on 6/03/16 around 7:30 am. -She told the MA to complete the required paperwork to return the medications to the pharmacy. -She had to go to the Assisted Living Unit of the facility to administer medications and did not complete the required paperwork to return the medications to pharmacy. Interview with a Personal Care Aide (PCA) on 6/16/16 at 2:29 PM revealed: -The MA had requested her assistance in counting the medications to return to the pharmacy on 6/03/16 around 8:00 am. -She was unable to assist the MA with counting the medications because she was busy assisting residents with breakfast. -She observed the MA had the medications out on the desk, but she was not sure what happened to the medications after that. -Law enforcement came to the facility after 2:00 pm on 6/03/16. Review of the facility's policies and procedures for controlled substances revealed: -The policy read; (g) Controlled substances that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored securely in a locked area separately from actively used medications until disposed of. Interview with a PCA on 7/07/16 at 2:40 pm revealed: -He worked in the SCU the day the medications went missing. -The Administrator did not really report what was going on when the medications went missing. -The Administrator searched staff purses and	D 397	PLEASE SEE ATTACHED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 397	Continued From page 53 cars. -His lunch bag was searched, but he did not own a car to be searched. Additional interview with Administrator (initially interviewed on 6/3/16) was unable to be conducted due to him no longer being employed by the facility.	D 397	PLEASE SEE ATTACHED	8/12/16
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, health care implementation and referral and follow-up and infection control. The findings are: A. Based on observations, interviews, and record review, the facility failed to ensure the level of supervision for the residents was modified after two altercations between 2 of 8 (#9 and #11) sampled Special Care Unit (SCU) residents with one altercation resulting in 27 staples to the scalp repeated falls for 1 of 8 sampled residents (#9)	D912	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D912	Continued From page 54 with one fall resulting in 11 staples to the scalp and a subsequent fall resulting in a hospitalization for both hydropneumothorax (air and fluid within the pleural space surrounding the lung) secondary to 3 broken ribs. [Refer to Tag 0270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A2 Violation)]. B. Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 8 sampled residents with regards to a psychiatric referral and a urinalysis (Resident #9). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. C. Based on observations, interviews, and record reviews the facility failed to assure implementation of orders for a resident that required dressing changes to a supra pubic catheter four times a day and for failure to implement orders for a surgical procedure for 1 of 1 sampled resident. (Resident #1). [Refer to Tag 0276 10A NCAC 13F .0902(c)(4)Health Care (Type A2 Violation)]. D. Based on observations, interviews, and record reviews the facility failed to implement infection control procedures consistent with Center for Disease Control and Prevention guidelines on infection control regarding the sharing of glucometers between residents for 5 of 5 sampled residents (Resident #17, #18, #19, #20 and #21). [Refer to Tag 932 General Statute 131D 4.4 A(b) Adult Care Home Infection Control Prevention Requirements (Type B Violation)].	D912	PLEASE SEE ATTACHED	8/12/16
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements	D932	PLEASE SEE ATTACHED Addendums made to this tag on POC per telephone conversation 8.18.16 NZ	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 55 G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 56 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to implement infection control procedures consistent with Center for Disease Control and Prevention guidelines on infection control regarding the sharing of glucometers between residents for 5 of 5 sampled residents (Resident #17, #18, #19, #20 and #21). The findings are: Interview on 07/07/16 at 11:15 am with the Resident Care Director (RCD) and the Resident Care Coordinator (RCC) revealed the facility had 5 residents receiving Finger Stick Blood Sugar (FSBS) monitoring. Observation on 07/07/16 at 7:45 am of the blood glucose monitoring revealed: -The first shift Medication Aide (MA) removed a glucometer pouch from the bottom drawer of the medication cart. -Two glucometer pouches where located in the bottom drawer of the medication cart. -The pouch was labeled with the resident's name. -There was a Brand A glucometer not labeled with the resident's name and two single use lancets in the pouch. -The MA took the glucometer pouch, alcohol swab and gloves to the resident's room. -The MA explained to the resident she was taking her blood sugar, the MA donned gloves, removed the glucometer from the pouch, placed a test strip in the glucometer, wiped the right index finger	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 57 with an alcohol swab, obtained a blood sample. -The MA disposed of the lancet in a biohazard container located on the medication cart. -The MA placed the glucometer into black pouch and placed in the medication cart. Observation on 07/07/16 at 9:00 am of the facility's medication carts revealed: -Two medication carts in the Special Care Unit (SCU) which contained two Brand A glucometers, both pouches were labeled with a resident's name, but the glucometers were not labeled. -Two medication carts in the Assisted Living Unit (ALU) which contained 4 Brand A glucometers, three glucometer pouches were labeled with residents' names, the glucometers were not labeled; the other glucometer pouch contained a Brand A glucometer but neither the pouch nor the glucometer were labeled. Interview on 07/07/16 at 9:10 am with the MA on the ALU revealed: -She had been a MA at the facility for 4 months. -Each resident had their own glucometer. -You could recall the blood sugar readings from the glucometer memory by pushing a button on the side of the glucometer after it had been turned on. -The glucometer's memory button could be used if you forgot the last blood sugar reading. -She was unsure how to erase the glucometer's memory or how to set the glucometers to the accurate date and time. -She had not seen instructions for use of the glucometers. -She used alcohol swabs to clean the glucometers after each use. -There was a "house" glucometer which could be used for an emergency if needed. -She had completed diabetic training and	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 58 infection control training prior to administering medications in the facility. -The Regional Nurse had completed her training and signed off on her medication competency validation check list. Interview on 07/07/16 at 9:15 am with a second MA on the ALU revealed: -She had worked as a MA at the facility for 7 months. -Each resident had their own glucometer. -She had cleaned the glucometers with alcohol swabs each time she used the glucometers. -The memory on the glucometers "stays in till we erase the reading." -The MAs erase the glucometer memory weekly on all the glucometers. -The "house" glucometer was for emergency only, "I have never used it." -The facility policy was to clean the glucometers after each use. -The MAs were responsible for checking the controls "high and Low" on the glucometers weekly. -The RCC checked behind the MAs to make sure "we are cleaning and running the controls on the glucometers." -"If we have problems with the glucometers we go the RCC for concerns." Interview on 07/07/16 at 9:25 am with the RCC revealed: -She was responsible for the nursing staff on the ALU. -The MAs were to clean the glucometers after each use with disinfectant wipes provided by the facility. -The disinfectant wipes were located on each medication cart. -She conducted Medication Administration	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 59 Record (MAR) audits and compared the blood sugar readings to the MARs. -She was aware the facility had a house glucometer and it was to be used for emergency only. -The last time she had completed glucometer audits for the ALU was in June 2016 the middle of the month. -The last time she completed glucometer audits for the SCU was maybe a month ago. -She had not cleared the memory history in any glucometer on the ALU or the SCU. Observation on 07/07/16 at 10:25 am of all medication carts in the facility revealed all carts had disinfectant germicidal Environmental Protection Agency (EPA) approved wipes located in the bottom drawers. Interview on 07/07/06 at 9:45 am with the MA in the SCU revealed: -She had been employed as a MA for 1 year in the facility. -She had completed diabetic training and infection control training with the Regional Nurse. -She was aware the policy was to clean the glucometers after each use, but she had waited till her morning medication pass was completed to clean the 2 glucometers in the SCU. -She said she used the disinfectant wipes to disinfect each glucometer, she wrapped each glucometer in the wipe and let it set for 3-5 minutes. -She was unaware how to set the glucometers to appropriate date and time. -She was unaware where the instruction manual was for the glucometers. -She never completed the high and low control checks on the glucometers. -She was unaware how to clear the glucometer	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 60 memory, "I think the nurse does that." Interview on 07/07/16 at 9:35 am with the RCD revealed: -She had been the RCD in the SCU for 3 weeks. -She was unaware the glucometers were not labeled with the residents' name. -She completed MAR audits daily to compare medications and to look for "holes" in the MAR. -She had never compared glucometer readings to the MARs. -The MAs were to disinfect the glucometers after each use with the appropriate disinfectant wipes located on all the medication carts. -She had not completed diabetic training with the SCU staff since she had been in the SCU. -She had not seen any MAs do the high and low control check on the glucometers and had no documentation they had completed this. -She was unsure which MAs were clearing the memory in the glucometers. -The memory for the glucometers was usually cleared by the third shift staff in all the other facilities she had worked in. Interview on 07/07/16 at 9:50 am with the Regional Nurse revealed: -She completed the diabetic training for all new MA. -She observed MAs obtaining a resident's FSBS and then disinfecting the glucometers during diabetic training. -She used hands on as well as observations for completing the medication validation check off list for the MAs. -The MAs were to clean the glucometer after each use. -The MAs were not to clear the memory of the glucometers only the RCC and the RCD. -The facility had a turn-over in staff, "A lot of the	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 61 MAs are new to the facility." Review of the 6 Brand A glucometer's memory and FSBS history for all 5 residents with the RCD and the RCC revealed: -Five pouches were labeled with residents' names, none of the Brand A glucometers were labeled. -One glucometer pouch was not labeled nor was the glucometer and was identified as a "House" glucometer. -All 6 glucometers were not set to appropriate date or time. -One glucometer was set to Spanish language. -All 6 Brand A glucometers had consecutive readings of FSBS in the memory that did not match the appropriate residents' MARs. Interview on 07/07/16 at 11:15 am with the RCC and the RCD revealed: -They were not aware the consecutive readings in the residents' glucometer's memory did not match the documentation on the MARs. -The MAs should be using the blood sugar readings from each resident's glucometer to establish accurate blood sugar reading and then document the blood sugar on the MAR. -The MAs could be documenting blood sugars on the MAR without checking FSBS on the residents. -They would immediately do an in-service for all MAs on diabetes, glucometers, and documentation on the MAR for the ALU and the SCU. -They would check glucometer's memory and compare the FSBS readings to the MARs daily for 2 weeks then weekly. -They would immediately label each of the Brand A glucometers with the resident's name and remove the "House" glucometer.	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 62 Telephone interview on 07/08/16 at 1:45 pm with a representative for the manufacturer of the Brand A glucometers revealed: -The manufacturer had supplied the facility with glucometers for each diabetic resident in the facility. The glucometer can be used for more than one resident. -The instructions are to wipe down the glucometer with mild soap and water. -Each glucometer comes preset with appropriate date, time and language. -Each glucometer comes with an instruction manual for re-setting the date and time. -The manufacturer has a telephone number the facility may call for any issues or problems with the glucometers. -When asked, there were no instructions for disinfecting the Brand A glucometers. Review of the manufacturer cleaning instructions for the Brand A glucometers located in a manual provide by the facility obtained on the computer on 07/07/16 at 4:00 pm revealed: -Recommended to clean the glucometer after each use. -Gently wipe the glucometer with a soft cloth that had been dampened with 70% alcohol solution. -No disinfecting instructions were given in the manual. A. Review of Resident #19's current FL2 dated 12/18/15 revealed: -Diagnoses included dementia and diabetes. Review of Resident #19's record revealed a signed physician order dated 4/27/16 for FSBS checks two times daily.	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 63 Review of Resident #19's July 2016 blood sugar flow sheet revealed: -Resident #19 was receiving blood sugar monitoring 2 times daily. -There were 13 readings on the blood sugar monitoring form as follows: -On 7/1/16 at 7:00 am FSBS 108, at 4:00 pm FSBS 162. -On 7/2/16 at 7:00 am FSBS 110, at 4:00 pm FSBS 201. -On 7/3/16 at 7:00 am FSBS 106, at 4:00 pm FSBS 169. -On 7/4/16 at 7:00 am FSBS 115, at 4:00 pm FSBS 201. -On 7/5/16 at 7:00 am FSBS 112, at 4:00 pm FSBS 232. -On 7/6/16 at 7:00 am FSBS 147, at 4:00 pm FSBS 249. -On 7/7/16 at 7:00 am FSBS 99. Review of Resident #19's glucometer memory in chronological order revealed: -A Brand A glucometer and was not labeled with Resident #19's name. -The glucometer was not set to accurate date or time. -The glucometer was set to Spanish language. -The glucometer had 6 FSBS reading in the memory which were as follows: -01 reading =99 matched the FSBS on 7/7/16 at 7:00 am. -02 reading =249 matched the FSBS on 7/6/16 at 4:00 pm. -03 reading =147 matched the FSBS on 7/6/16 at 7:00 am. -04 reading =232 matched the FSBS on 7/5/16 at 4:00 pm. -05 reading =162 matched the FSBS on 7/1/6 at 4:00 pm. -06 reading =108 matched the FSBS on 7/1/6 at	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 64 7:00 am. -There was 7 additional FSBS documented on the blood sugar flow sheet from that were not found in the glucometer memory. -No other FSBS readings were in Resident #19's glucometer memory . B. Review of Resident # 17's current FL2 dated 10/30/15 revealed: -Diagnoses that included dementia and diabetes. -An order for FSBS monitoring three times daily before meals. -An order for Lantus (used as a long acting insulin to decrease blood glucose level in the blood) 30 units daily in the morning and Lantus 10 units at bedtime. -An order for Novolog (a fasting acting insulin for reducing blood glucose) sliding scale with FSBS as follows: -FSBS less than 200 no insulin. -FSBS 201-250 give 2 units. -FSBS 251-300 give 4 units. -FSBS 301-350 give 6 units. -FSBS 350-400 give 8 units. -FSBS over 400 call Medical Doctor. Review of Resident #17's record revealed: -A six month renewal signed physician order dated 4/27/16 increased Lantus 35 units every morning and increased Lantus 25 units at bedtime. Review of Resident #17's July 2016 blood sugar flow sheet revealed: -There were 19 readings on the blood sugar monitoring form as follows: -On 7/1/16 at 7:30 am FSBS 108, at 11:30 am FSBS 197, at 4:30 pm FSBS 252. -On 7/2/16 at 7:30 am FSBS 183, at 11:30 am FSBS 222, at 4:30 pm FSBS 199.	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 65 -On 7/3/16 at 7:30 am FSBS 120, at 11: 30 am FSBS 199, at 4:30 pm FSBS 183. -On 7/4/16 at 7:30 am FSBS 179, at 11:30 am FSBS 201, at 4:30 pm FSBS 199. -On 7/5/16 at 7:30 am FSBS 200, at 11:30 am FSBS 242, at 4:30 pm FSBS 317. -On 7/6/15 at 7:30 am FSBS 166, at 11: 30 am FSBS 197, at 4:30 pm FSBS 243. -On 7/7/16 at 7:30 am FSBS 106. Review of Resident #17's glucometer memory in chronological order revealed: -A Brand A glucometer and was not labeled with Resident #17's name. -The glucometer was not set to accurate date or time. -The glucometer had 9 FSBS readings in the memory which were as follows: -01 reading = 106 matched the FSBS on 7/7/16 at 7:30 am. -02 reading = 243 matched the FSBS on 7/6/16 at 4:30 pm. -03 reading = 197 matched the FSBS on 7/6/16 at 11:30 am. -04 reading = 166 matched the FSBS on 7/6/16 at 7:30 am. -05 reading = 317 matched the FSBS on 7/5/16 at 4:30 pm. -06 reading = 242 matched the FSBS on 7/5/16 at 11:30 am. -07 reading = 200 matched the FSBS on 7/5/16 at 7:30 am. -08 reading = 209 did not match any FSBS entry. -09 reading = 179 matched the FSBS on 7/4/16 at 7:30 am. -There was 2 additional FSBS documented on Resident 17's blood sugar flow sheet, on 7/4/16 at 11:30 am FSBS 201, and on 7/4/16 at 4:30 pm FSBS 199, that were not found in the glucometer	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 66 memory. -No other FSBS readings were in Resident #17's glucometer memory. C. Review of Resident # 18's current FL2 dated 4/29/16 revealed: -Diagnoses which included dementia and diabetes. -An order for blood sugar monitoring three times daily. -A medication order Novolin R (a fasting acting insulin to reduce blood glucose levels) give 9 units three times daily with meals hold if BS less than 150. -A medication order for Levemir (a long acting insulin that reduces blood glucose levels) 50 units at bedtime. Review of Resident #18's July 2016 blood sugar flow sheet revealed: -There were 18 documented readings on the blood sugar monitoring form as follows: -On 7/1/16 at 7:00 am FSBS 154, at 11:30 am FSBS no FSBS, at 4:30 pm FSBS 161. -On 7/2/16 at 7:00 am FSBS 192, at 11:30 am FSBS 155, at 4:30 pm FSBS 189. -On 7/3/16 at 7:00 am FSBS 160, at 11: 30 am FSBS 166, at 4:30 pm FSBS 191. -On 7/4/16 at 7:00 am FSBS 136, at 11:30 am FSBS 206, at 4:30 pm FSBS 263. -On 7/5/16 at 7:00 am FSBS 178, at 11:30 am FSBS 181, at 4:30 pm FSBS 255. -On 7/6/16 at 7:00 am FSBS 191, at 11: 30 am FSBS 159, at 4:30 pm FSBS 166 -On 7/7/16 at 7:00 am FSBS 199. Review of Resident #18's glucometer memory in chronological order revealed: -A Brand A glucometer and was not labeled with Resident #18's name.	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 67 -The glucometer was not set to accurate date or time. -The glucometer had 13 FSBS readings in the memory which were as follows: -01 reading = 199 matched the FSBS on 7/7/16 at 7:00 am. -02 reading = 166 matched the FSBS on 7/6/16 at 4:30 pm. -03 reading = 159 matched the FSBS on 7/6/16 11:30 am. -04 reading = 191 matched the FSBS on 7/6/16 at 7:00 am. -05 reading = 255 matched the FSBS on 7/5/16 at 4:30 pm. -06 reading = 181 matched the FSBS on 7/5/16 at 11:30 am. -07 reading = 178 matched the FSBS on 7/5/16 at 7:00 am. -08 reading = 263 matched the FSBS on 7/4/16 at 4:30 pm. -09 reading = 206 matched the FSBS on 7/4/16 at 11:30 am. -10 reading = 134 did not match any FSBS reading. -11 reading = 191 matched the FSBS on 7/3/16 at 4:30 pm. -12 reading = 166 matched the FSBS on 7/3/16 at 11:30 am. -13 reading = 189 matched the FSBS on 7/2/16 at 4:30 pm. -There was 2 additional FSBS entries on Resident #18's blood sugar flow sheet, on 7/3/16 at 7:00 am FSBS 160, and on 7/4/16 at 7:00 am FSBS 136, that were not found in the glucometer memory. -No other FSBS readings were in Resident #18's glucometer memory. D. Review of Resident #20's current FL2 dated 01/04/16 revealed:	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 68 -Diagnoses included dementia and diabetes. -A medication order for Levemir (a long acting insulin that reduces blood glucose) 30 units two times daily. -An order for Novolog (a fast acting insulin to reduce blood glucose) Flex Pen per sliding scale protocol. Review of Resident # 20's record revealed: -Signed physician 6 month renewal orders dated 05/06/16 for the following medications: -FSBS 4 times daily before meals and at bedtime. -Levemir 45 units every morning. -Novolog 5 units three times daily with meals. -Levemir 45 units at every evening. -Novolog sliding scale: less than 150 no insulin, 151-200= give 3 units, 201-250 give 6 units, 251-300= give 9 units, 301-351= give 12 units, 351-400= give 15 units, 401-450= give 18 units, 451-500= give 21 units, over 500 call MD. Review of Resident #20's July 2016 blood sugar flow sheet revealed: -There were 25 documented readings on the blood sugar monitoring form as follows: -On 7/1/16 at 7:00 am FSBS 166, at 11:30 am FSBS 201, at 4:30 pm FSBS 211, at 8:00 pm FSBS 270. -On 7/2/16 at 7:00 am FSBS line drawn through the FSBS, at 11:30 am FSBS 235, at 4:30 pm FSBS 206, at 8:00 pm FSBS 292. -On 7/3/16 at 7:00 am FSBS 202, at 11: 30 am FSBS 179, at 4:30 pm FSBS 196, at 8:00 pm FSBS 289. -On 7/4/16 at 7:00 am FSBS 252, at 11:30 am FSBS 202, at 4:30 pm FSBS 237, at 8:00 pm FSBS 241. -On 7/5/16 at 7:00 am FSBS 257, at 11:30 am FSBS 227, at 4:30 pm FSBS 247, at 8:00 pm FSBS 340.	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 69 -On 7/6/16 at 7:00 am FSBS 264, at 11: 30 am FSBS 250, at 4:30 pm FSBS 255, at 8:00 pm FSBS 264. -On 7/7/16 at 7:00 am FSBS 300. Review of Resident #20's glucometer memory in chronological order revealed: -A Brand A glucometer and was not labeled with Resident #20's name. -The glucometer was not set to accurate date or time. -The glucometer had 11 FSBS readings in the memory which were as follows: -01 reading = 300 matched the FSBS on 7/7/16 at 7:00 am. -02 reading = 205 did not match any FSBS reading. -03 reading = 264 matched the FSBS on 7/6/16 at 8:00 pm. -04 reading = 255 matched the FSBS on 7/6/16 at 4:30 pm. -05 reading = 250 matched the FSBS on 7/6/16 at 11:30 am. -06 reading = 264 matched the FSBS on 7/6/16 at 7:00 am. -07 reading = 75 did not match any FSBS reading. -08 reading = 340 matched the FSBS on 7/5/16 at 8:00 pm. -09 reading = 247 matched the FSBS on 7/5/16 at 4:30 pm. -10 reading = 223 did not match any FSBS reading. -11 reading = 257 matched the FSBS reading on 7/5/16 at 7:00 am. -There were 3 additional readings in the Brand A glucometer, reading #02 FSBS 205, reading #07 FSBS 75, and reading #10 FSBS 223, that did not match Resident 18's blood sugar flow sheet. -No other FSBS readings were in Resident #18's	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 70 glucometer memory. E. Review of Resident #21's current FL2 dated 03/18/16 revealed: -Diagnoses of dementia. -An order for FSBS monitoring 2 times weekly. Review of Resident #21's May, June, and July 2016 blood sugar flow sheet revealed: -There were no documented FSBS on June and July 2016 blood sugar monitoring form, "refused" was documented 2 times weekly. -May 2016 there were two documented FSBS on the blood sugar monitoring form, 5/14/16 FSBS 108 and on 5/25/16 FSBS 106. Review of Resident #21 glucometer memory in chronological order revealed: -A Brand A glucometer and was not labeled with Resident #21's name. -The glucometer was not set to accurate date or time. -The glucometer had 8 FSBS reading in the memory which were as follows: -01 reading = 106 matched the FSBS on 5/25/16. -02 reading = 310 did not match FSBS on 5/14 16. -03 reading = 237 did not match FSBS on 5/14 16. -04 reading = 148 did not match FSBS on 5/14/16. -05 reading = 169 did not match FSBS on 5/14/16. -06 reading = 144 did not match FSBS on 5/14/16. -07 reading = 145 did not match FSBS on 5/14/16. -08 reading = 167 did not match FSBS on 5/14/16.	D932	PLEASE SEE ATTACHED	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 71 -On the blood sugar flow sheet for May 2016, Resident #21 had an entry on 5/25/16 FSBS 106 that matched reading #01. -No other FSBS readings were in Resident #21's glucometer memory. Review of the house glucometer memory in chronological order revealed; -A Brand A glucometer and was not labeled. -The glucometer was not set to accurate date or time. -The glucometer had 2 FSBS readings in the memory which were as follows: -01 reading = 357. -02 reading = 41. -No other FSBS readings were in the house glucometer memory. Review of the facility glucometer policy revealed: -Each resident will have their own glucometer to be used solely for that resident. -Glucometer audits will be performed at least weekly by the RCD or ED. -Glucometers are to be cleaned after each use with germicidal towelettes per labeled directions. Interview on 07/07/16 at 3:50 pm with the Director of Operations and the Director of Clinical Services revealed: -They were aware each resident in the facility had their own glucometers. -They were not aware MAs were clearing the memory in the resident's glucometers. -The MAs were not to delete the memory in the residents' glucometers that was management responsibility. -The RCC and the RCD were to clear the memory from the residents' glucometers. -They were not aware the residents' glucometers did not have the appropriate date and time	D932	PLEASE SEE ATTACHED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060130	A. BUILDING: _____ B. WING _____	C 07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D932	Continued From page 72 available. -"If the dates and times on the glucometers do not match how can that be an infection control issue." -Maybe the MAs were deleting the history daily in the residents' glucometers. _____ A plan of protection was provided by the facility on 07/07/16: -Effective immediately, the MA will be in-serviced not to clear the memory history on the resident's glucometers. -In-service MA to clean with 70 % alcohol wipes after each use. -Facility will label all glucometers with resident's names immediately. -The RCD/RCC/ED will audit glucometers weekly to ensure accuracy. -The facility will continue to use individual use only glucometers. -Facility will continue to implement infection control training during orientation process. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 22, 2016.	D932	PLEASE SEE ATTACHED	8/12/16

S. W. Sugate
8/12/2016

The Crossings of Steele Creek

Plan of Correction – Survey July 6th – July 8th

10A NCAC 13F .0901(b) Personal Care and Supervision

Correction Date 8/7/16

Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

- Facility will identify residents who are at risk for falls and/or behaviors will be placed on frequent checks for safety. All care staff will be in-serviced on proper documentation and interventions.
- ED, RCD, RCC and/or designee will review documentation and determine additional interventions necessary weekly for 1 month, bi-weekly thereafter.
-

define frequency

+Define → Biweekly or Bimonthly?

10A NCAC 13F .0902(b) Health Care → Implement appropriate interventions immediately for @ risk residents

Correction Date 8/7/16

The facility shall assure referral and follow up to meet the routine and acute health care needs of residents.

- All medication aides have been in serviced to utilize the new order tracking form for all new orders and treatments to include labs.
- MAR-Cart-Chart audit was conducted by outside source and facility has completed follow up to recommendations
- ED, RCD, RCC and/or designee will follow up to ensure notification to PCP when unable to obtain labs.
- ED, RCD, RCC and/or designee will review and audit daily all new order tracking to ensure accuracy and implementation.

10A NCAC 13F .0902 (c) (3-4)

Correction Date 8/7/16

The facility shall assure documentation of the following in the resident's records: 3. Written procedures, treatments, or orders from a physician or licensed health professional; and 4. Implementation of procedures, treatments or orders specified in Subparagraph (c) (3) of this Rule.

- All Medication aides will be in serviced to utilize the new order tracking form for all new medication and treatment orders. — Referrals
- MAR-Cart-Chart audit was conducted by outside source and facility has completed follow up to recommendations
- ED, RCD, RCC and/or designee will review and audit daily all new order tracking to ensure accuracy and implementation — of all MD orders

10A NCAC 13F .1002 (a) Medication Orders

Correction Date 8/22/16

(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.

- ED, RCD, RCC have been in-serviced on Clarification of Order form and the rule area.
- All Medication Aides have been or will be in-serviced on the "Clarification of Order" form and rule area by the correction date. Any Medication Aide who has not been in-serviced as of the Correction Date will not be allowed to return to the cart until they have been properly trained.

→ Include On-going monitoring - frequency & who is responsible.

10A NCAC 13F .1004(a) Medication Administration

Correction Date 8/22/16

(a) An adult care home shall assure that the preparation and administration of medications, prescriptions 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 records; and (2) rules in this section and the facility's policies and procedures

- ED, RCD, RCC have been in-serviced on Clarification of Order form and the rule area.
- All Medication Aides have been or will be in-serviced on the "Clarification of Order" form and rule area by the correction date. Any Medication Aide who has not been in-serviced as of the Correction Date will not be allowed to return to the cart until they have been properly trained.
- ED, RCD/, RCC and/or designee will review and audit daily all controlled substance storage procedures for 4 weeks, then biweekly to ensure accuracy and implementation.

10A NCAC 13F .1004(g) Medication Administration

Correction Date 8/22/16

The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations.

- The facility will conduct Medication Observations of all Medication Aides prior to Correction Date.
- ED, RCD, RCC and/or designee will continue to complete Medication Observations on a random rotation bi-weekly.

10A NCAC 13F .1004(n) Medication Administration

Correction Date 8/22/16

(n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.

- The facility will conduct Medication Observations of all Medication Aides
- ED, RCD, RCC and/or designee will continue to complete Medication Observations on a random rotation. — Include frequency

10A NCAC 13F .1008 (f) Controlled Substance

Correction Date 8/22/16

(f) Controlled substances that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored securely in a locked area separately from actively used medications until disposed of

- All Medication Aides have been or will be in-serviced on the controlled substance locked procedures and return procedures by the correction date. Any Medication Aide who has not been in-serviced as of the Correction Date will not be allowed to return to the cart until they have been properly trained.
- ED, RCD/, RCC and/or designee will review and audit daily all controlled substance storage procedures for 4 weeks, then biweekly to ensure accuracy and implementation.

G.S. 131D-21 (2) Declaration of Residents' Rights

Correction Date 8/22/16

Every Resident shall have the following rights: 2. to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

- Facility will identify residents who are at risk for falls and/or behaviors will be placed on frequent checks for safety. All care staff will be in-serviced on proper documentation and interventions.
- ED, RCD, RCC and/or designee will review documentation and determine additional interventions necessary weekly for 1 month, bi-weekly thereafter.
- All medication aides have been in serviced to utilize the new order tracking form for all new orders and treatments to include labs.
- MAR-Cart-Chart audit was conducted by outside source and facility has completed follow up to recommendations
- ED, RCD, RCC and/or designee will follow up to ensure notification to PCP when unable to obtain labs.

- ED, RCD, RCC and/or designee will review and audit daily all new order tracking to ensure accuracy and implementation.
- ED, RCD, RCC have been in-serviced on Clarification of Order form and the rule area.
- All Medication Aides have been or will be in-serviced on the "Clarification of Order" form and rule area by the correction date. Any Medication Aide who has not been in-serviced as of the Correction Date will not be allowed to return to the cart until they have been properly trained.
- The facility will conduct Medication Observations of all Medication Aides prior to Correction Date.
- ED, RCD, RCC and/or designee will continue to complete Medication Observations on a random rotation bi-weekly.

G.S. 131D-4.4A (b) ACH Infection Prevention Requirements

Correction Date 8/22/16

(b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other blood borne pathogens, each adult care home shall do all of the following, beginning January 2012: (1) Implement a written infection control policy consistent with federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: (a) Proper disposal of single-use equipment used in puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. (b) Sanitation of rooms and equipment, including cleaning procedures, agents and schedules. (c) Accessibility of infection control devices and supplies (d) Blood and bodily fluid precautions. (e) Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other blood borne pathogens. (f) Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C and other blood borne pathogens.

- In serviced Medication aides to NOT clear glucometers
- In services Medication aides to clean glucometers after each use with 70% alcohol wipe — Not CID based
- All glucometers have been labeled individually, pouches are still labeled
- In serviced ED, RCD, RCC to audit glucometers weekly to ensure compliance
- Facility will continue to use individual use only glucometers
- Facility will continue to implement State Infection Control training during the Orientation process for all staff. — and annually thereafter.

Reviewed + Accepted with revisions 8-19-16 [signature] RN

[signature], Executive Director 08/12/2016