STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060087	A. BUILDING: _____ B. WING _____	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE SQUARE	5820 CAMEL ROAD CHARLOTTE, NC 28226

(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 May 3-4, 2017. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on March 10, 2017.	D 000	APPROVED POC DISCLAIMER "This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of (Name of Community) as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies."	
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure 2 of 6 non-nursing facility staff (Staff B and H) sampled had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to working in the facility. The findings are: 1. Review of Staff B's personnel file revealed: -Staff B was hired 4/30/14 as a Housekeeper. -There was no documentation the HCPR had been checked prior to hire in Staff B's personnel file. Observations on 5/03 and 5/04/17 were that Staff B was one of 2 Housekeepers cleaning the facility including the residents' rooms and the common rooms.	D 137		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alvenita M. Peeples | TITLE: Executive Director | (X6) DATE: 5-26-17

Reviewed and accepted
6/01/17 LJW

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D 137	Continued From page 1 Interview on 5/04/17 at 12:20 pm with the Business Office Manager (BOM) revealed: -She was not aware Staff B did not have a HCPR completed, so "I ran one today, with negative findings. I was on vacation when she was hired." -"The Housekeeping Director should have run her HCPR check." Telephone interview on 5/04/17 at 3:00 pm with Staff B revealed she was not aware a HCPR was to be completed, and was not aware what it was. Attempted interview on 5/04/17 with the Housekeeping Manager was unsuccessful. Review of a HCPR check for Staff B received from the BOM on 5/04/17, dated 5/04/17 revealed no substantiated findings on the registry. Refer to interview on 5/04/17 at 12:20 pm with the BOM. Refer to interview on 5/04/17 at 3:30 pm with the Administrator. 2. Review of Staff H's personnel file revealed: -Staff H was hired 2/13/17 as a Dietary Aide. -There was no documentation the HCPR had been checked prior to hire in Staff B's personnel file. Interview on 5/04/17 at 12:20 pm with the Business Office Manager (BOM) revealed: -She was not aware Staff H did not have a HCPR completed, so "I ran one today, with negative findings." -"The Kitchen Manager should have run her HCPR check."	D 137	**Response to D 137** Administrator and Business Office Manager will ensure that each staff member hired have no substantial findings listed on the North Carolina Health Care Personnel Registry. Business Office Manager will provide Administrator with application at time of interview along with Health Care registry listing. Administrator will monitor through spot checks on a monthly basis as well. May 22, 2017	

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Interview on 5/04/17 at 3:40 pm with the Food Service Director revealed:
-She completed reference checks on new hires, but did not complete HCPR checks.
-The BOM completed the "other required checks" that included the HCPR check on new hires.

Attempted telephone interview on 5/04/17 at 4:10 pm with Staff H was unsuccessful.

Review of a HCPR check for Staff H received from the BOM on 5/04/17, dated 5/04/17 revealed no substantiated findings on the registry.

Refer to interview on 5/04/17 at 12:20 pm with the BOM.

Refer to interview on 5/04/17 at 3:30 pm with the Administrator.

Interview on 5/04/17 at 12:20 pm with the Business Office Manager (BOM) revealed:
-She had worked at the facility for 11 years and was in charge of making sure the HCPR checks were completed.
-"The department heads (Kitchen and Housekeeping) should run their own HCPR check on staff before they are hired. I am a second set of eyes to make sure the (HCPR) check was completed."

Interview on 5/04/17 at 3:30 pm with the Administrator revealed:
-The BOM was responsible for making sure the HCPR check was completed on new hires.
-"When an applicant comes in, I want to see that the HCPR was done to make sure of their credentials, and to verify there were no findings reported."

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D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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, record reviews, and interviews, the facility failed to assure medications (metformin and clonazepam) were administered as ordered by a licensed prescribing practitioner for 1 of 3 residents (#1) observed during a medication pass.

The findings are:

The medication pass error rate was 7% as evidenced by 2 medication errors observed out of 27 observations.

Review of Resident #1's current FL-2, dated 03/24/17, revealed diagnoses included diabetes mellitus II, depression, and anxiety.

1. Review of Resident #1's FL-2 dated 03/24/17, revealed a physician's order for metformin 500 mg two times a day. (Metformin is used to lower blood sugar.)

Review of Resident #1's record revealed:
-A laboratory tests result sheet dated 12/08/16

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with a recorded hemoglobin A1C (HgA1C) value of 7.7. (HgA1C is a laboratory test for measuring the blood sugar over an extended length of time. The American Diabetes Association 2016 guidelines recommend HgA1C less than 8 for long term diabetics.)
-A laboratory tests results sheet dated 03/31/17 with a HgA1C value of 9.0.
-A subsequent physician's order from Resident #1's primary care Physician's Assistant (PA), dated 03/31/17, for metformin 500 mg take 2 tablets (1000 mg) twice a day.

Observation of the morning medication pass on 05/04/17 at 7:45 am revealed:
-Resident #1 was observed at the medication cart outside the dining room waiting for her medications
-The medication aide (MA) prepared 10 oral medications for Resident #1.
-The medications included metformin 500 mg.
-Just after the metformin was administered, the resident moved into dining room and began eating breakfast.

Review of Resident #1's electronic medication administration record (eMARs) for April 2017 and May 2017 revealed:
-An entry for Metformin 500 mg give one tablet two times a day, scheduled at 8:00 am and 5:00 pm daily.
-Administration was documented at 8:00 am and 5:00 pm daily from 04/01/17 at 8:00 am to 05/04/17 at 8:00 am.

Observation of Resident #1's medication on hand for administration on 05/04/17 revealed:
-A bingo card packaged for morning administration, labeled for metformin 500 mg one tablet twice a day, dispensed on 4/13/17 for 30

Response to D 358

The facility RN – Personal Care Director and Assistant Personal Care Director will ensure that all medications are administered as ordered by a physician. Personal Care Director will in-service all Med Techs on the proper procedures for administration of medications.

When orders are changed by a physician the bingo card is sent back to the pharmacy for a new card with the correct dosing. If there is an issue with insurance covering the new medication dosing, the pharmacy will notify the RN – Personal Care Director or Assistant Personal Care Director directly so that a sticker is placed on the medicationto alert the Medication Aide to refer to the e-MAR for new directions.

Med Techs will communicate all new orders and/or changes at shift change and via shift communication notebook. The shift Med Techs will review changes and verify that all orders have been processed and verified via checking the e-MAR system.

In addition, the Personal Care Director and Assistant Personal Care Director will check daily to see if orders are processed, medications are received as ordered, and medications are returned to the pharmacy that cannot be used.

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tablets and 8 tablets remaining.
-A bingo card packaged for evening administration, labeled for metformin 500 mg one tablet twice a day, dispensed on 4/13/17 for 30 tablets and 9 tablets remaining.

Interview on 05/04/17 at 7:45 am with Resident #1 revealed:
-Staff administered her medications as ordered.
-As far as she knew, she was receiving her medications as ordered at the present time.

Interview on 05/04/17 at 11:30 am with the medication aide (MA) revealed:
-She was not aware Resident #1 had any recent orders from her primary care PA for changes to her medications.
-Resident #1 did not have an order for Metformin 1000 mg twice a day on the eMAR.

Telephone interview on 05/04/17 at 10:20 am with Resident #1's primary care PA revealed:
-He had increased Resident #1's metformin from 500 mg to 1000 mg twice a day on 03/31/17 as a result of the increase in the resident's HgA1C from the laboratory results on 03/31/17.
-The new order was electronically sent to the facility for processing.
-He was not aware Resident #1 was not receiving metformin 1000 mg twice a day as ordered.
-He expected the facility to administer medications as ordered, "that is why I order the medication."

Interview on 05/04/17 at 11:50 am with the Assistant Resident Care Director (ARCD) revealed:
-She was not aware of the order for Resident #1's metformin 1000 mg twice a day dated 03/31/17.
-All orders, whether written, faxed or received

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electronically, were supposed to be faxed to the contract pharmacy before placing in the residents' records (a copy of the fax conformation was supposed to be attached to the order).
-The order must have been received by the facility and filed in Resident #1's record without being faxed to the pharmacy or left for the FN or ARCD to process because there was no fax confirmation attached to the order filed in the record.
-The medication aides did not administer metformin as ordered because the current order was not on the eMAR.
-She would correct the order immediately and notify the primary care PA.
-The pharmacy entered the orders on the eMAR.
-The ARCD and the Facility Nurse checked the eMARs for accuracy when entered by the pharmacy.

Telephone interview on 05/04/17 at 12:18 pm with a representative of the contract pharmacy revealed:
-The facility was responsible to fax all medication orders to the pharmacy for review and processing to the eMARs.
-The pharmacy dispensed metformin 500 mg twice a day from a signed physician's order dated 02/22/17 and the current FL-2 dated 03/24/17.
-The pharmacy dispensed 62 metformin 500 mg, labeled on tablet twice a day on 3/13/17.
-The pharmacy dispensed 60 metformin 500 mg, labeled on tablet twice a day on 4/13/17.
-The pharmacy did not receive the order for metformin 500 mg 2 tablets (1000 mg) twice a day dated 03/31/17.

Interview on 05/04/17 at 3:28 pm with the Facility Nurse (FN) revealed:
-She was not aware of the order for Resident #1's

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metformin change from 500 mg to 1000 mg twice a day.
-Routinely, the primary care PA would sent a visit summary for any changes made to a resident's medication if the PA saw the resident on his visit.
-The PA must have reviewed the laboratory tests information dated 03/31/17 and sent the order for 1000 mg metformin twice daily to the facility without seeing the resident.
-The order just have been filed in Resident #1's record without faxing to the pharmacy or placing in the box designated for review by the FN or ARCD.

Refer to interviews on 05/04/17 at 8:00 am and 11:30 am with the medication aide (MA).

Refer to interview on 05/04/17 at 3:30 pm with the Facility Nurse (FN).

Refer to interview on 05/04/17 at 4:00 pm with the Administrator.

2. Review of Resident #1's record revealed:
-A physician's order from Resident #1's primary care Physician's Assistant (PA), dated 04/21/17, ordering clonazepam 0.5 mg one-half tablet twice a day, as needed. (Clonazepam is used for nervousness/anxiety.)
-A physician's order from Resident #1 primary care PA, dated 04/28/17, for clonazepam 0.5 mg one tablet three times a day, as needed.

Observation of the morning medication pass on 05/04/17 at 7:45 am revealed:
-Resident #1 was observed at the medication cart outside the dining room waiting for her medications.
-Resident #1 requested her "nerve" medication.
-The MA retrieved a bubble package labeled "prn"

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(as needed) from the locked controlled substance drawer of the medication cart and punched one-half tablet (pre-packed) from the bubble package.
-The bubble package was labeled clonazepam 0.5 mg, pre-packaged with one-half tablet in each bubble, and dispensed on 04/21/17 for a quantity of 60 of the ½ tablets (equaling 30 tablets).
-The MA documented one-half tablet administered on Resident #1's clonazepam 0.5 mg controlled drug count sheet for the tablets dispensed on 04/21/17 (labeled one-half tablet twice a day) leaving 47 tablets in the bingo package.
-The medication aide (MA) prepared 10 oral medications for Resident #1.
-The medications included one-half tablet of clonazepam 0.5 mg (ordered one tablet on 04/28/17).

Observation of Resident #1's medication on hand for administration on 05/04/17 at 11:45 am revealed:
-A bubble package labeled "prn" (as needed) from the locked controlled substance drawer of the medication cart and punched one-half tablet (pre-packed) from the bubble package.
-The bubble package was labeled clonazepam 0.5 mg, pre-packaged with one-half tablet in each bubble, and dispensed on 04/21/17 for a quantity of 60 doses of the ½ tablets (equaling 30 tablets).
-Forty seven tablets remained in the bubble package.

Review of Resident #1's electronic medication administration record (eMARs) for April 2017 revealed:
-An entry for clonazepam 0.5 mg one-half tablet twice a day, as needed
-Administration was documented 2 times a day

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from 04/21/17 to 7:40 am on 04/28/17.
-Clonazepam 0.5 mg one-half tablet twice a day, as needed was discontinued on the eMAR on 04/28/17.
-An entry for clonazepam 0.5 mg one tablet three times a day, as needed starting 04/28/17.
-Clonazepam 0.5 mg was documented administered 2 times on 04/28/17, 4/29/17, and 04/30/17.

Review of Resident #1's May 2017 eMARs revealed:
-An entry for clonazepam 0.5 mg one tablet three times a day, as needed.
-Clonazepam 0.5 mg was documented for administration 2 times a day on 05/01/17 (at 7:42 am and 1:17 pm), one time on 05/02/17 (7:35 am), 3 times on 05/03/17 (7:35 am, 1:32 pm, and 7:58 pm) and one time on 05/04/17 at 7:45 am.

Review of administration documented on Resident #1's clonazepam 0.5 mg controlled drug count sheet for the 60 doses of 1/2 tablet of clonazepam 0.5 mg dispensed on 04/21/17 and labeled one-half tablet twice a day as needed revealed:
-On 04/30/17, 1 dose (1/2 tablet) at 2:00 pm, and one dose at 9:00 pm was documented.
-On 05/01/17, 1 dose (1/2 tablet) at 8:00 am; 1 dose at 2:00 pm, and one dose at 9:00 pm was documented.
-On 05/02/17, 1 dose (1/2 tablet) at 8:00 am; 1 dose at 2:00 pm, and one dose at 9:00 pm was documented.
-On 05/03/17, 1 dose (1/2 tablet) at 8:00 am; 1 dose at 2:00 pm, and one dose at 9:00 pm was documented.
-On 05/04/17, 1 dose (1/2 tablet) at 8:00 am was documented and 47 doses remained.
-Resident #1 should have been receiving 2 doses

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of the one-half tablets to equal one tablet of clonazepam 0.5 mg as ordered on 04/28/17.

Based on the number of tablets dispensed and the number of doses documented as administered, Resident #1 was administered clonazepam 0.25 mg dose (ordered 04/21/17) instead of clonazepam 0.5 mg dose ordered on 04/28/17 from 04/28/17 to 05/04/17 at 7:45 am (observed during the medication pass).

Interview on 05/04/17 at 7:45 am with Resident #1 revealed:
-Staff administered her medications as ordered.
-As far as she knew, she was receiving her medications as ordered at the present time.

Telephone interview on 05/04/17 at 10:20 am with Resident #1's primary care PA revealed:
-He had changed Resident #1's clonazepam 0.5 mg one tablet three times a day, as needed.
-He was not aware Resident #1 was not receiving clonazepam 0.5 mg as ordered.
-He expected the facility to administer medications as ordered, "that is why I order the medication."

Interview on 05/04/17 at 11:30 am with the medication aide (MA) revealed:
-She was aware Resident #1 had any recent orders from her primary care PA for changes to her clonazepam.
-She was aware Resident #1's clonazepam 0.5 mg was changed from 2 times a day as needed, to 3 times a day as needed.
-She overlooked the change to one tablet of clonazepam 0.5 mg instead of one-half tablet.
-Routinely, the contract pharmacy sent a new bubble package when the directions or strength of a medication changed.

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-She did not know why the pharmacy did not send the clonazepam 0.5 mg packaged as a whole tablet when the directions and strength changed.
-The facility had a sticker to put on the clonazepam indicating the MA should refer to the eMAR for new directions that would help alert the staff of the change.
-She would place a sticker on the resident's clonazepam.

Telephone interview on 05/04/17 at 12:18 pm with a representative of the contract pharmacy revealed:
-The facility was responsible to fax all medication orders to the pharmacy for review and processing to the eMARs.
-The pharmacy received the order to change Resident #1's clonazepam 0.5 mg from one-half 2 times a day as needed to clonazepam one tablet 3 times a day as needed on 04/28/17.
-The pharmacy discontinued the old order and added the new order to the eMAR on 04/28/17.
-The pharmacy did not send a new bubble package because the resident's insurance would not pay for the medication more than one time in a 30 day period.
-The pharmacy expected the facility to use 2 of the one-half tablets to equal one tablet as ordered since the strength of the medication was the same.
-There was no documentation that the pharmacy had contacted the facility to inform the facility that the medication would need to be administered using 2 of the bubble package doses.

Interview on 05/04/17 at 3:30 pm with the Facility Nurse (FN) revealed:
-She was not aware the medications aides were not administering Resident #1's clonazepam as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060087	A. BUILDING: _____ B. WING _____	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE SQUARE	5820 CAMEL ROAD CHARLOTTE, NC 28226

(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 12 -She did random audits of the residents' medication orders compared to the eMAR but did not audit the medication carts for medication compared to the eMAR. -No medication staff had informed her there was a question regarding Resident #1's clonazepam and how they should administer the medication. Refer to interviews on 05/04/17 at 8:00 am and 11:30 am with the medication aide (MA). Refer to interview on 05/04/17 at 3:30 pm with the Facility Nurse (FN). Refer to interview on 05/04/17 at 4:00 pm with the Administrator. _____ Interviews on 05/04/17 at 8:00 am and 11:30 am with the medication aide (MA) revealed: -The Facility Nurse (FN) was responsible to all new medication orders for accuracy compared to the eMAR. -MA staff only reviewed medication orders in the residents' records if the MA need clarification on the instructions for administration of a medication. -She was not aware Resident #1 had any recent orders from her primary care PA for changes to her medications. -The contract pharmacy routinely provides new bingo cards when a medication order has changed. -The residents' medications were supposed to be administered according to the eMAR. Interview on 05/04/17 at 3:30 pm with the Facility Nurse (FN) revealed: -She was the facility nurse and the Resident Care Director (RCD). -All medication orders, including physician visit summaries, FL-2s, and hospital discharge	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060087	A. BUILDING: _____ B. WING _____	05/04/2017

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D 358	Continued From page 13 summaries, were supposed to be faxed to the contract pharmacy provider. -A copy of the medication orders were left for her review before filing in the residents' records. -The contract pharmacy was responsible to enter all medication orders into the eMAR system. -The ARCD and FN were responsible to review medications orders compared to the eMAR and approve or correct the order entries on the eMAR. -Medication aides administered medications according to orders on the residents' eMARs. Interview on 05/04/17 at 4:00 pm with the Administrator revealed: -The FN and ARCD, and medication aides were responsible for assuring residents' medications were administered as ordered. -The FN and ARCD were responsible for assuring the eMARs were correct for the current medication orders of the residents. -She was not aware Resident #1 was not receiving medications as ordered.	D 358		