STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060104	A. BUILDING: _____ B. WING _____	09/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS IN THE VILLAGE AT CAROLINA PLACI	13180 DORMAN ROAD PINEVILLE, NC 28134

(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 on 09/26/17 and 09/27/17.	D 000	10A NCAC 13F .0902(c)(3-4) Health Care Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.	
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: Based on observations, interviews, and record reviews, the facility failed to assure orders for finger stick blood sugars (FSBS) were implemented as ordered for 1 of 5 sampled residents (Resident #5). The findings are: Review of Resident #5's current FL2, dated 12/22/16 revealed diagnoses of type 2 diabetes, hypertension, congestive heart failure, cardiomyopathy, and coronary artery disease. Review of Resident #5's Resident Register revealed an admission date of 12/29/16. Review of Resident #5's subsequent physician's orders revealed: -A physician's order dated 9/5/17 for FSBS checks before meals and at bedtime daily -A physician's order dated 9/18/17 to hold insulin	D 276	A. With Respect to the Specific Residents Cited: Resident #5 was not injured nor had any adverse effects as a result of this deficiency. Upon this deficiency being brought to our attention, the community contacted the resident's physician. The physician stated that the resident's blood sugar levels have been stable and feels there were no episodes of hypoglycemia. Orders were also clarified. B. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: The community conducted an in-service for all med techs and LPN's regarding the importance of clarifying orders. Med techs will notify the nursing staff when/if they have questions about a order and/or if there is conflicting information. The Resident Service Director/ LPN/ Designee will contact the physician for further clarification accordingly. C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern: Upon receiving new MARs and/or Orders, the Resident Service Director/LPN/ Designee will conduct a two-step check on new MAR's/ Orders, to insure all orders are clear. Each designee will sign-off (2 signatures) the orders accordingly, for accuracy and clarify any	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jason T. Fisher — TITLE: Administrator/ED — (X6) DATE: 11/18/17

JASON T. FISHER

Reviewed and Accepted 11/14/17 KHH

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D 276	Continued From page 1 if before meal blood sugar is less than 120 mg/dl. Review of Resident #5's September 2017 Medication Administration Record (MAR) revealed: -An entry for FSBS to be obtained before meals and at bed time and FSBS documented at 8 am, 12 pm, and 8 pm. -There was no documentation for FSBS checks before dinner. -The FSBS ranged from 79-314 from 9/6/17-9/26/17. Interview on 9/26/17 at 4:50 pm with primary care physician revealed that order was written on 9/5/17 for blood sugars to be checked 4 times per day; before meals and at bedtime to monitor high blood sugars. Interview on 9/26/17 at 4:55 pm with Licensed Practical Nurse (LPN) on duty revealed: -She worked for the facility for 2 months. -Resident #5 had an order for FSBS to be taken daily before meals. -LPNs were responsible for receiving physician's orders and transcribing them on the MAR and another LPN was responsible for checking for the entries for accuracy. -LPNs were responsible for checking FSBSs and recording them on the MAR according to the physician's orders. -FSBS were recorded on the treatment MAR only. Interview on 9/27/17 at 8:20 am with another LPN on duty revealed: -She transcribed Resident #5's physician's order for FSBSs on to the MAR incorrectly as the order was for before meals and at bedtime. -"She forgot to include a space for blood sugars to be recorded before dinner".	D 276	discrepancies with physician, if needed. This will be continued going forward. D. With Respect to How the Plan of Corrective Measures will be Monitored: The Resident Service Director/LPN/Designee will conduct random audits of MARs/orders, at he beginning of each month. Further, random audits will be conducted at least 1x/week going forward. This audit will be for checking any new orders transcribed into the MARs accordingly. Sample size will be at least five (5) different charts each audit. Executive Director will review any discrepancies with the Resident Service Director/LPN/Designee and monitor compliance on a monthly basis. This plan is in effect and should be fully implemented no later than thirty (30) days upon submitting this Plan of Correction, November 8, 2017.	

11/8/17

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D 276	Continued From page 2 -She was a new employee when it was transcribed and another LPN verified that it was written correctly. -She did not work evenings and was unsure if FSBS checks were taken before dinner. -She had checked Residents #5's FSBS before breakfast and lunch meals and administered insulin as ordered. Interview on 09/27/17 at 8:30 am and 10:05 am with Resident #5 revealed: -She had lived at the facility since the beginning of the year. -She was unsure of how long she had been a diabetic. -Facility staff checked FSBS daily before meals (3 times per day) -She thought blood sugars were supposed to be checked 3 times per day as that was when she received insulin. -There were no days blood sugars are not checked before meals. Interview on 09/27/17 at 9:30 am and 9:55am with Resident Services Director (RSD) revealed: -She was the only Registered Nurse (RN) for the facility and oversaw all staff who provide patient care. -The LPNs were to receive new orders from physicians and transcribe them on the treatment MAR and fax to the pharmacy. -She did not go behind the LPNs to ensure orders were transcribed correctly as there are too many orders being received from the physician. -LPNs worked together, once an order had been transcribed by an LPN, then double checked by another LPN for accuracy. -She interpreted the physician order for Resident #5 for FSBS to be taken twice per day, before breakfast and at bedtime as it was her	D 276		

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D 276	Continued From page 3 understanding of the abbreviations written by the physician. -She thought the LPN transcribed the order incorrectly and it would be corrected. Interview on 09/27/17 at 10:00 am with the pharmacy representative revealed that they did not have an order for FSBS for Resident #5. Interview 09/27/17 at 10:38 am with the Administrator revealed: -LPNs were responsible for receiving orders from physicians and transcribing on the MAR. -He was not sure why the MAR was transcribed incorrectly. -He did not realize the resident had order FSBS checks 4 times per day. Telephone Interview on 9/27/17 at 12:16 pm with a 2nd shift LPN revealed: -She worked as the 2nd shift (3 pm-11 pm) LPN and was responsible for FSBS checks for Resident #5. -She thought Resident#5 was ordered to receive FSBS 4 times per day which were with meals and at bedtime because that was how it was written on the MAR. -She took the FSBS at dinner time and documented in 8PM slot. -She documented before dinner FSBS incorrectly on the treatment MAR because it was confusing. -She did not check FSBS at bedtime as she was confused about where to record on the MAR. -She was unsure to why she did not ask for clarity. -She did not take FSBS at bedtime. Review of a written statement received from physician on 9/27/17 revealed: -He understood blood sugars were checked only	D 276		

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D 276	Continued From page 4 3 times per day. -Upon reviewing the FSBS log, blood sugars have been stable and he did not feel that the patient had any episodes of hypoglycemia. -Blood sugars would continue to be monitored before meals and at bedtime. -The goal of treatment with an insulin regimen and oral hypoglycemic agents was to manage uncontrolled diabetes. -Resident #5 has a Hemoglobin A1c of 12% (test used to measure average blood glucose, the normal range is between 4 and 5.6%), which was recognized on recent patient evaluation.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (Resident #2) received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. (Refer to Tag 912 G.S.131D-21(2) Declaration of Residents' Rights)	D 338	10A NCAC 13F .0909 Resident Rights Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law. A. With Respect to the Specific Residents Cited: Resident #2 was not injured nor had any adverse effects as a result of this deficiency. Upon this deficiency being brought to our attention, the community contacted each staff member on shift, to look into this matter further. Based on staff response, this couldn't be definitively substantiated one way or the other. B.With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: The community has implemented additional 3rd shift visits, by management, unannounced. Shifts visit will occur at random hours each visit.	
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 5 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 observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (Resident #2) received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. The findings are: Review of Resident #2's current FL2 dated 09/26/17 revealed: -Diagnoses included Parkinson's disease, hypothyroidism, migraines, and pernicious anemia. -The resident was incontinent of bowel and bladder. Review of the Resident Register revealed Resident #2 was admitted to the facility on 10/13/16. Review of Resident #2's Care plan completed by facility staff and signed by the physician on 09/05/17 revealed Resident #2 needed extensive assistance with toileting, ambulation, bathing, dressing, grooming and transfer. Observation of Resident #2 on 09/26/17 at 11:15 am revealed: -Resident #2 was sitting in her electric wheelchair	D912	C. With Respect to What Systemic Measures have been put in place to Address the Stated Concern: Upon each unannounced shift visit. The designated manager will report their findings to the Administrator. As applicable and if necessary, any noted discrepancies or concerns will be addressed accordingly. The Resident Service Director had additional in-services with the SIC, to insure the roles and responsibilities of the SIC were understood, as it relates to resident care and staff supervision. D. With Respect to How the Plan of Corrective Measures will be Monitored: Based upon the findings on 3rd shift visits, will determine if whether or not any further action is required. If necessary, the Administrator / Resident Service Director/ Designee will respond accordingly, implementing other measures, as applicable. This plan is in effect and should be fully implemented no later than thirty (30) days upon submitting this Plan of Correction, November 8, 2017.	

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D912	Continued From page 6 at a table in her room. -There was no urine odor in the room. Interview on 09/26/17 at 11:15 am with Resident #2 revealed: -She required assistance with toileting and having her incontinent brief changed. -When she needed assistance she pushed her pendant and no one came to assist her. -She usually waited 20 minutes and pushed her pendant again. -She pushed her pendant again and again; waited "a long time" approximately 20 minutes. -She pushed her pendant three times on most occasions before she would receive staff assistance. -There were a few occasions when staff responded to the pendant call, but did not provide assistance and told her they were helping someone else and would be back. -Sometimes they returned and assisted her and sometimes she pushed the pendant again. -The resident was unable to recall exact dates or times when staff took a long time to respond to her pendant calls. Interview with Resident #2's private caregiver on 09/26/17 at 11:30 am revealed: -Resident #2 had 2 other private caregivers that rotated staying with the resident from 8:00 am to 11:00 pm every day of the week. -Resident #2 required two people to assist her to the bathroom. -Resident #2 required one person for transfers. -Resident #2 required assistance with bathing, dressing, feeding, transfers and repositioning. -Facility staff were to provide care to Resident #2 from 11 pm -8 am. -Resident #2 wore an incontinent brief with a heavy duty sanitary napkin in the brief and there	D912		

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D912	Continued From page 7 was a moisture barrier pad on her bed. -For the past three months, every day, when the private caregiver came in to care for Resident #2 in the mornings, she found her incontinent brief and the moisture absorbing pad that was on her mattress "soaked, wet with urine." -Resident #2 had plenty of incontinent supplies in the bedroom. -On the morning of 09/26/17, the bottom 2 inches of Resident #2's T-shirt was wet with urine. -She had talked with the Resident Service Director (RSD) about the problem of Resident #2 found to be soaked with urine each morning 2 months ago and the problem was corrected for about 2-3 weeks, but now was a problem again. -She had also spoken with the Medication Aides (MA) about her recent concerns with Resident #2's incontinent brief and T-shirt being found wet with urine in the mornings. -The MA told her that she would inform the RSD. -At night, the private caregiver pushed the pendant if she needed assistance with taking Resident #2 to the bathroom as the resident required 2 people to assist her. -She waited approximately 25 minutes and no staff came, so she assisted Resident #2 to the bathroom by herself without staff assistance. -Staff sometimes responded to the pendant call an hour or so later and sometimes they did not respond to the pendent call at all. Observation on 09/27/17 at 4:55 am of third shift facility staff on duty revealed: -The front door was locked and access to the facility was only through a telephone that called the supervisor on duty. -The surveyor had to call hang-up and recall the supervisor on duty six times due to the system ending calls after several rings and switching to the facility's voice mail system.	D912		

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D912	Continued From page 8 -After three and a half minutes the supervisor answered her the phone. -The Medication Aide/Supervisor (MA) came to the door. -There was no other staff in view. Observations of third shift Personal Care Aides (PCAs) on 09/27/17 at 5:00 am upon entrance to the facility revealed: -There was a residents' common sitting room on the second floor between resident rooms B205 and B207. -At 5:00 am the lights in the common sitting room was observed as being off. -A staff Person (PCA) had her eyes closed and sitting in a chair against the wall, feet up on a chair in front of her and a blanket wrapped around her. -Two other PCAs were observed getting off the elevator and they observed the AHS. -The two PCAs conversed with the AHS and quickly walked past the AHS toward the common sitting area where the third PCA was observed with her eyes closed sleeping. -The PCA observed with her eyes closed was awakened by the two PCAs. -The PCA that was in the chair with her eyes closed appeared groggy. -The PCA gathered her blanket and large bag of personal items and walked out of the room and started knocking on resident's doors. -She knocked and went into 2 residents' rooms and then picked up her bag and took out a set of keys. -The PCA was asked when her shift was over, and the PCA replied that she had to leave at 5:30 am to take her disabled daughter to catch the school bus. Second observation of Resident #2 on 9/27/17 at	D912		

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D912	Continued From page 9 5:15 am revealed: -Resident #2 was asleep in her bed. -Accompanied by the facility's Supervisor, Resident #2's incontinent brief was checked. -The Supervisor changed the resident's incontinent brief, and it was wet with urine, but not soaked. -The pad on Resident #2's bed was dry. -The resident's T-shirt was dry. -There was no urine odor in the resident's room. Observation on 9/27/17 between 5:15 am and 5:38 am of the staff who had been in the chair with the blanket wrapped around her on the second floor common sitting area revealed: -She came downstairs on the first floor and proceeded to go into a residents' room. -She stayed in the room for approximately 2 minutes with the Supervisor. -She came out wearing a medical throw-away disposable mask. -She left the first floor around 5:22 am. -The staff person was not in the facility at 5:38 am. Second interview with Resident #2's private caregiver on 09/27/17 at 9:15 am revealed: -When she came on duty at 8:00 am on 9/27/17, Resident #2's incontinent brief was only slightly wet with urine. Interview with the RSD on 9/27/17 at 9:35 am revealed: -Resident #2 moved into the facility about one year ago, and had always had private caregivers. -The private caregivers were with Resident #2 from 7:00 am to 11:00 pm. -The private caregivers assisted Resident #2 with transfers, bathing, toileting, feeding, dressing and changing her incontinent brief.	D912		

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D912	Continued From page 10 -Facility staff were expected to provide care to Resident #2 from 11:00 pm to 7:00 am when the private caregivers were not at the facility. -A couple of months ago Resident #2's caregiver made her aware of the concerns about Resident #2's incontinent brief was found soaked and wet with urine in the mornings. -She had talked with facility staff and reminded them that Resident #2 was to be checked on throughout the night and her incontinent brief was to be changed as needed. -She had not heard of any concerns since that time. Telephone interview with Resident #2's family member on 09/27/17 at 10:00 am revealed: -A private caregiver was expected to provide care for Resident #2 from 8:00 am to 11:00 pm every day. -Facility staff were expected to provide care to Resident #2 from 11:00 pm to 8:00 am. -A few months ago one of the private caregivers shared concerns with the family member regarding facility staff not checking on Resident #2 throughout the night, and found the resident's incontinent brief wet when the private caregivers checked on the resident in the morning. -The concerns were shared with the RSD and care of Resident #2 temporarily improved. -Recently one of the private caregivers shared that Resident #2 was found wet again in the mornings. -He had not shared these concerns with staff at the facility yet. Interview with the first shift Personal Care Aide (PCA) on 09/27/17 at 9:15 am revealed: -Resident #2 had a private caregiver that got the resident up and dressed in the mornings, brought the resident downstairs for all meals and provided	D912		

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D912	Continued From page 11 feeding assistance to her. -The private caregiver also took the resident to the bathroom, changed her incontinent brief and transferred her. -Facility staff was to provide assistance to the private caregiver with transferring Resident #2 as the resident required 2 people for assistance with transferring. -She heard concerns two times over the past year that third shift staff were not checking on Resident #2 frequently enough and she was being found wet with urine in the morning. -She shared the concerns about Resident #2 with the RSD. -She had not provided any care to Resident #2. Interview with the first shift Personal Care Aide (PCA) on 9/27/17 at 9:15 am revealed: -A third shift PCA told her that she slept during her shift. -She asked her what about caring for the residents and the third shift PCA responded that she would get up when her pager went off. -She reported her concerns about staff sleeping during third shift to a first shift supervisor, Licensed Practical Nurse (LPN). Interview with the RSD on 9/27/17 at 8:00 am revealed: -Staff that worked third shift were expected to be awake throughout their shift. -She expected the third shift Supervisor to be aware of staff's whereabouts throughout their shift. -She was not aware staff had been sleeping during third shift. -Staff working third shift were supposed to promptly answer residents' pendant calls and were to check on residents every 2 hours.	D912		

11/5/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060104	A. BUILDING: _____ B. WING _____	09/27/2017

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D912	Continued From page 12 Interview with the facility Administrator on 9/27/17 at 8:15 am revealed: -Staff were expected to take their breaks in the break room and they should not have blankets sleeping in the residents' common areas. -He reviewed the time sheet for the third shift staff person in question and she clocked out at 3 am on 9/27/17 for 45 minutes. -Third shift staff were supposed to provide care including incontinent care to residents and check on residents every 2 hours. Confidential interviews with staff revealed: -There was not enough help on the third shift. -When they came to work "we clean up third shift mess." -Third shift staff "does not do there job." -"Third shift staff is short all the time." -"Third shift staff will leave early." -The Registered Nurse "had favorites that do whatever they want." -"If you want to find out what happens on third shift, come see for yourself." Interview on 9/27/17 at 5:00 am and at 5:30 am with the Medication Aide/Supervisor (MA/S) revealed: -She was also the Supervisor on the third shift. -Her responsibilities were to administer medications to the residents and to oversee the staff on third shift. -All the staff carried a walkie-talky for communication with other staff persons. -There were always 5 staff working on third shift on 9/27/17. -There was a nurse who covered third shift at the facility and at a sister facility who was available by phone if needed. -She was unaware what the staff were during the interview.	D912		

11/5/17

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D912	Continued From page 13 -She was unaware staff were sleeping upstairs on the second floor in the common sitting area. -She was unaware the lights were out and staff were in a chair completely covered with a blanket, with her feet propped up in another chair. -She was unaware if the staff person had been sleeping on previous nights while working in the facility on third shift. -She would contact the on-call nurse for additional advise on what to do about the employee sleeping on the job. -"It is not ok if staff sleeps at work, they are to be working."	D912		

9/9/17