Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060144	A. BUILDING: _____ B. WING _____	11/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT BRIGHTMORE OF SOUTH CHARLC	10225 OLD ARDREY KELL ROAD CHARLOTTE, NC 28277

(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 November 20-21, 2017.	D 000		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure all that all fire safety equipment was maintained in a safe and operating condition related to 6 of 10 magnetic door locks in the memory care unit. The finding are: Observation on 11/20/17 at 10:33 am during the initial tour revealed: -The Memory Care Unit (MCU) was secured by magnetic lock doors designed to be opened by a coded keypad. -The magnetic lock doors had an emergency override switch to override the magnetic door lock in the event that the magnetic door locks failed to release the exit doors with activation of the fire alarm system. -There were 8 exit doors in the MCU that were locked with magnetic doors locks released by a coded key pad with a red emergency override switch covered by a plastic enclosure.	D 105		

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D 105	Continued From page 1 -There were 2 doors that exited the back patio of the Memory Care Unit with magnetic doors locks released by a coded key pad with red emergency override switchs covered by a plastic enclosure. -Four of the MCU exit doors and the 2 patio exit doors had padlocks on the plastic case over the red emergency override switches that required a key to unlock the padlock. Interview on 11/20/17 at 10:01 am with a Personal Care Aide (PCA) revealed: -She was hired at the facility in January 2017. -The Memory Care Unit was a locked unit. -The only way to exit the unit was to use a code or a key for the pad locks. -The locks were used to keep residents from getting outside the unit. -The padlocks on the emergency switch covers were used to keep residents from accessing the red emergency override switch and getting out of the unit. -There were 2 residents that had exited the unit after flipping the red emergency override switch. Those residents were no longer at the facility. Interview on 11/20/17 at 10:57 am with the Maintenance Director revealed: -There were 12 residents in the Memory Care Unit (MCU) and the policy was to practice once a month on various shifts for timely evacuation. -All doors that exit the unit have a magnetic release to allow the doors to open in an emergency. -The door would release with the fire alarm to allow the residents and staff to exit the unit and the building. -Staff used a code to exit any door in the unit and if the code or automatic door release did not work, then the red emergency override switch at	D 105		

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D 105	Continued From page 2 each door could be activated by lifting the plastic cover and flipping the switch. -There were 4 doors that exited the unit which had a padlock on the emergency switch. -Residents were known to have lifted the cover on the red emergency override switch and had gotten out of the facility. -Padlocks were added to the red emergency override switch release switch covers at the doors that exited the unit and the back patio. -The padlocks were added in April of 2017. -Everyone on staff should have a key. Observation on 11/20/17 at 3:56 pm and 3:59 pm of the fire drill revealed: -The Maintenance Director called the alarm company to inform them of the drill. -The alarm was activated at 3:56 pm and 3:59 pm. -All doors were checked to see if they released and none of the 8 magnetic lock doors released. -All 8 doors were unlocked using the code. -He called the local representative for the fire alarm company to report the problem with the doors. Interview on 11/20/17 at 4:07 pm with the Maintenance Director revealed: -He worked at the facility for 3 years. -He was not aware there were problems with the magnetic releases on the doors. -There was a fire in the kitchen last month and the magnetic release system worked and staff and residents were able to exit the unit and building without the use of the codes or red emergency override switches. -All of the doors were to release and open. -The facility participated in fire drills once a month on various days and shifts.	D 105		

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D 105	Continued From page 3 A Construction representative with the Adult Care Licensure Division was contacted on 11/20/17 at 4:30 and 11/21/17. Review on 11/20/17 at 4:31 pm of the Fire Drill notebook revealed: -The facility practiced a fire drill monthly with the last drill on 10/31/17 at 11:30 AM. -Six staff members participated and signed the fire drill attendance sheet. -The purpose of the fire drill was to check the evacuation procedure and timeliness. -The practice fire drill was initiated by the Maintenance Director with the staff and residents evacuated safely out of the building and accounted for. -The release of the magnetic doors was not checked in the simulation because the code was used to hold the door open for exit. -After the drill was complete an all clear was given by the Maintenance Director and the staff and residents were allowed to enter the facility. On 11/20/17 at 4:31 pm an attempted telephone interview with the Fire Marshall was unsuccessful. Observation on at 4:42 pm 11/20/17 of all of the red emergency switches revealed: -Four of the 8 red emergency switch boxes required a key for the pad lock attached in order to exit the building. -The padlocks were unlocked by the Maintenance Director with his key, an alarm sounded, the red emergency override switch was flipped and the magnetic locks were released and the doors opened. Observation on 11/20/17 at 4:58 pm of PCAs conducting an emergency evacuation using only	D 105		

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D 105	Continued From page 4 the red emergency switch boxes revealed: -Neither of the 2 PCAs was carrying a key to access the red emergency switch boxes. -Both PCAs identified the Medication Aide as the person who carried the key with them at all times. -Neither PCA could access the doors' red emergency override switch without the key. Interview on 11/20/17 at 5:44 pm with the Maintenance Director revealed: -They did not check to see if the magnetic's release the door during a fire drill. -A code was used to exit the front MCU to go out the front entrance of the building. -The staff were told that this is a drill, where the fire was and what door to exit. -The staff and residents were accounted for and then the "all clear" was given and the staff and residents were allowed back in the building. -A second accountability was performed after returning back into the building. -They did not check to see if the doors opened or not from the release of the magnetic locks. Based on observations and interviews, the facility failed to assure all that all fire safety equipment was maintained in a safe and operating condition related to 6 of 10 magnetic door locks in the memory care unit. Six exits doors had red emergency override switches used in the event the magnetic door locks did not open when the fire alarm system was activated. The red emergency override switches were padlocked and unable to be opened in a timely manner in case of a fire and evacuation of residents. The facility's failure to assure the fire equipment was maintained in a safe condition was detrimental to the safety of the residents and constitutes a Type B Violation.	D 105	Prefix Tag: D 105 Padlock removed from switch covers. Installed plastic, break-away padlocks – as approved by DHSR DHSR – Construction Section representative on site and tested magnetic locks – confirming that magnetic locks released the doors when the fire alarm pull-box was activated, Magnetic locks will be monitored to confirm releasing during monthly fire drill performed by Maintenance Director.	11/21/17 11/27/17 11/22/17 On-going

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D 105	Continued From page 5 Review of the Plan of Protection provided on 11/20/17 revealed: -The padlocks were removed from the plastic covers of the emergency override switches. -All fire and safety equipment is to be evaluated for proper operating conditions. -Staff will continue to be trained upon hire and in-serviced on procedures for emergency evaluation by the supervisor of prior to the staff member's next shift. -The emergency override switch plastic cover boxes were labeled for identification. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, JANUARY 5, 2017.	D 105		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 2 of 4 sampled staff (Staff A and Staff B) had no substantiated findings on the North Carolina Health Care Personnel Registry. The findings are:	D 137		

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D 137	Continued From page 6 A. Review of Staff A employee file revealed: -Staff A was hired on 10/09/17 as a housekeeper. -Staff A had no documentation of a Health Care Personnel Registry Check (HCPR) being completed prior to 11/21/17. -The Business Office Manager (BOM) completed a HCPR check for Staff A on 11/21/17. -Staff A did not have any findings on the HCPR. Staff A was not available for interview on 11/21/17. Interview on 11/21/17 at 11:35 am with the BOM revealed: -The the receptionist/administrative assistant was responsible for completing HCPR checks upon hire of new employees. -The Administrator of the BOM were responsible to monitor staff employement records for completeness. -The BOM could not explain why the receptionist/Administrative Assistant did not complete the HCPR check on Staff A. Interview on 11/21/17 at 2:30 pm with the Administrator revealed: -She was aware that HCPR checks were required for all staff. -She thought the receptionist/Administrative Assistant had checked all employee files when she was informed that all employees needed to be checked on the HCPR. Refer to interview on 11/21/17 at 1:15 pm with receptionist/Administrative Assistant. B. Review of Staff B employee file revealed: -Staff B did not have an employee file set up in the facility.	D 137		

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D 137	Continued From page 7 -Staff B had no documentation of a HCPR being completed. Interview on 11/21/17 at 12:31 pm with Staff B revealed: -Staff B was a contract chef hired by a company that managed the kitchen by ordering, preparing, and serving food to the resident's in the facility. -Staff B was not considered the Food Service Director (FSD). -He was filling in for the FSD who resigned from the position about 2 weeks ago. -Staff B did know what a HCPR check was. -Staff B stated that his employee file was in the home office of the contracted company. Interview on 11/21/17 at 11:35 am with the BOM revealed: -The kitchen staff were workers hired by a contracted company to manage the kitchen for food preparation. -The contracted company was responsible for completing their own employee files. -The facility only completed tuberculosis test and drug screens on the kitchen staff. -BOM was not aware that the contracted staff needed HCPR checks completed upon hire. -The receptionist/Administrative Assistant was responsible for completing the HCPR checks upon hire. -BOM was aware that HCPR checks was required for all staff, but she did not think about including the food service staff because the staff were considered contract workers. Interview on 11/21/17 at 2:30 pm with the Administrator revealed: -She was aware that HCPR checks was required for all staff. -She thought the receptionist/Administrative	D 137		

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D 137	Continued From page 8 Assistant had checked all employee files when the Adult Home Specialist informed us that all employees needed to be checked on the HCPR. -She did not think to do HCPR checks on the kitchen staff because the workers were contracted employees. -She planned to meet with the new Food Service Director and the contracted company to ensure all required information was gathered on the kitchen staff. Refer to interview on 11/21/17 at 1:15 pm with receptionist/Administrative Assistant. Interview on 11/21/17 at 1:15 pm with receptionist/Administrative Assistant revealed: -She was responsible for looking up all staff on the HCPR upon hire. -She was told to do HCPR checks on new hires, but she forgot to add HCPR checks to her new hire checklist. -In the past, she only completed the HCPR check list for nursing staff. -She added the HCPR check to her checklist for all staff on 11/21/17. -HCPR checks were performed on Staff A and Staff B prior to exiting with no substantiated findings for either. The facility failed to ensure 2 of 4 sampled staff (Staff A and Staff B) had a North Carolina Health Care Personnel Registry check prior to date of hire. The facility not knowing if staff had substantiated findings placed all resident at risk for neglect or abuse and constitutes a Type B Violation. The facility provided a Plan of Protection as follows: -Health Care Personnel Registry (HCPR) check	D 137	Prefix Tag: D 137 HCPR completed for both Staff A & B by Business Office Manager and copies placed in respective personnel files. Employee charts audited and HCPR completed and copies in all employee file. BOM responsible for all HCPR checks for all employees and new hires, including contracted dining employees. New orientation checklist for contracted dining created and in use. BOM will complete monthly audit of new hires, the last week of each month.	11/21/17 11/23/17 On-going On-going

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D 137	Continued From page 9 will be completed for all newly hired employees going forward. -The Business Office Manager (BOM) will review employee files that currently exist to ensure all HCPR checks are in the files. -All files will be documented. -The BOM will review employee files periodically for compliance and will complete checks at hire of employee. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 5, 2017.	D 137		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (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: Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up for 1 of 3 sampled residents (Resident #3) regarding physician notification of blood pressure lower than 110/70 or pulse rate lower than 60. The findings are: Review of Resident #3's current FL2 dated 7/06/17 revealed: -Diagnoses included hypertension (high blood pressure) and mild dementia. -A physician order for lisinopril 10 mg one tablet	D 273		

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D 273	Continued From page 10 one time a day for hypertension. Hold for blood pressure less than 110/70 or pulse lower than 60, call to notify MD (physician) and await new orders. (Lisinopril is used to treat high blood pressure.) -A physician order for metoprolol tartrate 25 mg one tablet two times a day for hypertension. Hold for blood pressure less than 110/70 or pulse lower than 60, call to notify MD (physician) and await new orders. (Metoprolol is used to treat high blood pressure and increased heart rate.) Review of Resident #3's September 2017 electronic Medication Administration Records (eMARs) revealed: -Preprinted entries for lisinopril 10 mg one tablet one time a day for hypertension and metoprolol tartrate 25 mg one tablet two times a day for hypertension. Hold for blood pressure less than 110/70 or pulse lower than 60, call to notify MD (physician) and await new orders was included on both orders. -Lisinopril 10 mg one tablet one time a day was documented for administration at 10:00 am daily from 09/01/17 to 09/30/17 (except at 10:00 am on 09/10/17, 09/17/17, and 09/24/17 when resident was out of the facility). -Metoprolol tartrate 25 mg one tablet two times a day was documented for administration at 10:00 am and 5:00 pm daily from 09/01/17 to 09/30/17 (except at 10:00 am on 09/10/17, 09/17/17, and 09/24/17 when resident was out of the facility). Continued review of the September 2017 eMAR revealed: -Documentation for blood pressure (BP) and pulse values recorded at 10:00 am and 5:00 pm daily from 09/01/17 to 09/30/17 (except at 10:00 am on 09/10/17, 09/17/17, and 09/24/17 when resident was out of the facility).	D 273		

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D 273	Continued From page 11 -Blood pressure values were documented less than 110/70 on 10 of 57 opportunities in September 2017. -No pulse rates documented less than 60. -Examples of BP values less than 110/70 were as follows: on 09/02/17 at 10:00 am- BP was 121/65, on 09/05/17 at 5:00 pm- BP was 136/69, on 09/14/17 at 10:00 am- BP was 113/63, and on 09/28/17 at 5:00 pm- BP was 106/64. Review of Resident #3's October 2017 electronic eMAR revealed: -Preprinted entries for lisinopril 10 mg one tablet one time a day for hypertension and metoprolol tartrate 25 mg one tablet two times a day for hypertension. Hold for blood pressure less than 110/70 or pulse lower than 60, call to notify MD (physician) and await new orders was included on both orders. -Lisinopril 10 mg one tablet one time a day was documented for administration at 10:00 am daily from 10/01/17 to 10/31/17 (except at 10:00 am on 10/09/17, 10/22/17, 10/25/17, and 10/29/17 when the resident was out of the facility). -Metoprolol tartrate 25 mg one tablet two times a day was documented for administration at 10:00 am and 5:00 pm daily 10/01/17 to 10/31/17 (except at 10:00 am on 10/09/17, 10/22/17, 10/25/17, 10/29/17; and 5:00 pm on 10/22/17 and 10/27/17, when the resident was out of the facility). Continued review of the October 2017 eMAR revealed: -Documentation for blood pressure (BP) and pulse values recorded at 10:00 am and 5:00 pm daily from 10/01/17 to 10/31/17 (except at 10:00 am on 10/09/17, 10/22/17, 10/25/17, 10/29/17; and 5:00 pm on 10/22/17 and 10/27/17, when the resident was out of the facility).	D 273		

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D 273	Continued From page 12 -Blood pressure values were documented less than 110/70 on 13 of 56 opportunities in October 2017. -No pulse rates documented less than 60. -Examples of BP values less than 110/70 were as follows: on 10/5/17 at 10:00 am- BP was 115/66, on 10/05/17 at 5:00 pm- BP was 117/67, on 10/08/17 at 10:00 am- BP was 114/66, and on 10/31/17 at 5:00 pm- BP was 130/60. Review of Resident #3's November 2017 electronic eMAR revealed: -Preprinted entries for lisinopril 10 mg one tablet one time a day for hypertension and metoprolol tartrate 25 mg one tablet two times a day for hypertension. Hold for blood pressure less than 110/70 or pulse lower than 60, call to notify MD (physician) and await new orders was included on both orders. -Lisinopril 10 mg one tablet one time a day was documented for administration at 10:00 am daily from 11/01/17 to 11/20/17. -Metoprolol tartrate 25 mg one tablet two times a day was documented for administration at 10:00 am and 5:00 pm daily from 11/01/17 to 11/20/17 at 10:00 am). Continued review of the November 2017 eMAR revealed: -Documentation for blood pressure (BP) and pulse values recorded at 10:00 am and 5:00 pm daily from 11/01/17 to 11/20/17. -Blood pressure values were documented less than 110/70 on 17 of 39 opportunities in November 2017. -There were no pulse rates documented less than 60. -Examples of BP values less than 110/70 were as follows: on 11/02/17 at 10:00 am- BP was 137/63, on 11/07/17 at 10:00 am- BP was 95/57, on	D 273		

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	HAL060144	A. BUILDING: _____ B. WING _____	11/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT BRIGHTMORE OF SOUTH CHARLC	10225 OLD ARDREY KELL ROAD CHARLOTTE, NC 28277

(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 13 10/19/17 at 10:00 am- BP was 166/69, and on 11/19/17 at 5:00 pm- BP was 150/60. Review of Resident #3's record revealed: -No documentation the physician had been contacted regarding blood pressure values less than 110/70 for September, October, or November 2017. -No documented falls or episodes of dizziness or lightheadedness due to low blood pressure. Interview on 11/21/17 at 12:30 pm with the Resident Care Director (RCD) revealed: -The facility had no documentation they had contacted Resident #3's practitioner about blood pressures less than 110/70. -The medication aides (MAs) should be taking Resident #3's blood pressure and following the parameters of the order for notifying the physician for blood pressures less than 110/70. -MAs should have been contacting Resident #3's physician regarding instructions for administering Resident #3's blood pressure medications. Interview on 11/21/17 at 1:30 pm with the Administrator revealed: -The RCD would be responsible for reviewing the residents' medication orders and assuring staff were following medication orders, including notifying residents' physicians according to orders. -Resident #3's eMAR and electronic progress notes revealed no documentation for MAs notifying Resident #3's physician for blood pressures less than 110/70. -She was not aware MAs were not notifying the physician as ordered. Interview on 11/21/17 at 1:40 pm with a Medication Aide(MA) revealed:	D 273		

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D 273	Continued From page 14 -The MAs were supposed to notify the physician when a resident had an order like Resident #3's. -The MA on duty called the physician to notify him of low blood pressures according to physicians' orders. -The MA had to add the blood pressure values to the eMAR prior to administering the medication due to the way the order was entered into the eMAR system. -MA staff must have overlooked reading the complete order. -The eMAR system had an electronic progress notes section for staff to document physician notification. -She did not recall if she had notified Resident #3's physician for BP values less than 110/70 as ordered. Interview on 11/21/17 at 1:50 pm with Resident #3 revealed; -Staff take her blood pressure routinely before administering her medication. -She was not aware of the order to notify her physician for certain parameters. -She had not seen her physician recently. -Her blood pressure was very hard to control and was up and down, mostly elevated. -She had not experienced any episodes of lightheadedness or dizziness that she thought would have been from low blood pressure. Telephone interview on 11/21/17 at 2:10 pm with a representative for Resident #3's physician revealed: -There was not documentation that the facility staff had notified the physician's office for blood pressures less than 110/70. -The physician would have expected the facility to follow the order to notify the office for blood pressure less than 110/70.	D 273	Prefix Tag: D 273 Administrator trained current Med-Techs on following med order parameters. Electronic MAR now has an alert to remind Med-Techs of special physician's ordered parameters of medications. New Resident Care Coordinator will monitor daily using Progress Notes Report and Daily Checklist to ensure compliance and follow up is completed. Received new medication orders, for Resident #3, with new parameters that are more specific for better compliance by Med-Techs. Administrator or RCC will sign-off on all new physician ordered parameters.	11/21/17 12/14/17 On-going 11/29/17 On-going

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D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic diet menu for 1 of 1 sampled residents (Resident #1) with orders for a low concentrated sweets (LCS) diet. The findings are: Review of Resident #1's current FL2 dated 11/18/16 revealed diagnoses included mild vascular dementia, diabetes type II, hypertension, hyperlipidemia, osteoporosis s/p (symptoms post) compound fracture, depression, left breast cancer, and skin cancer. Review of Resident #1's record revealed a diet order dated 11/9/16 for a LCS diet. Observation on 11/20/17 at 10:15 am of the kitchen revealed: -A list of residents and their physician ordered diets. -Three out of 26 residents, including Resident #1, were listed as having a diet order for LCS. -A diet spreadsheet labeled Memory Care/Assisted Living menus 2017 was posted. -The diet spreadsheet included menus for regular, no added salt diets. -There was no menu for the LCS diet.	D 296		

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D 296	Continued From page 16 Observation on 11/20/17 of the week at a glance lunch menu revealed residents on a regular diet were to be served 6 ounces (oz.) vegetable soup, 8 oz. eggplant parmesan, 1 turkey burger sandwich, 1 tablespoon (1 tbsp.) grated parmesan cheese, 1/2 cup (c.) pear halves, 4 oz. spaghetti with marinara sauce 1/2 c. grilled yellow squash, 1 slice apple pie, 1 dinner roll, 1 tuna melt on wheat. Observation on 11/20/17 of the lunch meal revealed: -Resident #1 was served eggplant parmesan, vegetable soup, sweet potatoes with butter, tea, and water. -Resident #1 consumed 100% of the eggplant parmesan, 100% of the sweet potatoes, 100% of the vegetable soup, none of the tea, and 50% of the water. -Staff offered Resident #1 a cup of unsweetened applesauce, but she refused. -Without a therapeutic spreadsheet, it could not be determined if Resident #1 was served the LCS diet as ordered by the physician. Observation on 11/21/17 of the week at a glance breakfast menu revealed residents on a regular diet were to be served 4 oz. choice of orange juice, 4 oz. 2% milk, ½ c. fresh fruit cup, 4 oz. grits, 2 pancakes, 2 slices pork bacon, 1 slice whole wheat toast, 1 cinnamon roll, salt and pepper, sugar and creamer, margarine and coffee. Observation on 11/21/17 of the breakfast meal revealed: -Resident #1 was served 1 sausage patty, oatmeal, french toast with sugar free syrup, orange juice, ½ banana, and water.	D 296		

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D 296	Continued From page 17 -Resident #1 consumed 100% of all food items. -Without a therapeutic spreadsheet, it was unable to be determined if Resident #1 was served the LCS diet as ordered by the physician. Interview on 11/21/17 at 10:15 am with the Executive Chef (EC) revealed: -He had been employed with the facility for almost 3 years. -There was no one employed as the Dietary Manager at that time. -He and another dietary staff member were working together to complete the duties of the previous dietary manager. -He had never received any food service training to serve as the Dietary Manager. -He did not use a menu for the LCS diet. -He used the regular menu and substituted regular desserts with sugar free desserts for the residents on a LCS diet. -He looked in the computer to find a LCS menu but was unable to find it. -He had not notified the administrator that he was unable to find a LCS diet menu. Interview on 11/21/17 at 12:55 pm with the Registered Dietitian (RD) contracted to provide therapeutic menus for the facility revealed: -She had been the RD for the contracted food supply company for 2 years. -Her company provided menu services to the facility but did not provide consultation. -Her company offered an updated menu whenever requested by the facilities. -Each time a facility needed new menus, they were required to send an email identifying what therapeutic diets they offered. -Her company would provide a menu spreadsheet listing what foods to be served for a regular diet and each of the identified therapeutic	D 296		

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D 296	Continued From page 18 diets. -On 11/21/17, the facility had sent an email requesting a spreadsheet for a LCS menu. -She was unsure if the facility previously requested a menu for LCS. -The facility should not use the regular diet menu for residents ordered a LCS diet. -The LCS menu differed from the regular menu in that it replaced regular drinks with sugar free drinks, required smaller portioned desserts, replaced skim milk for 2% milk, and sometimes required a different carbohydrate to be served. Interview on 09/15/17 at 12:25 pm with the Administrator revealed: -She was aware the facility should have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. -She was unaware that dietary staff were not using a LCS menu. -The previous dietary manager requested therapeutic menus from contracted facility and served therapeutic diets as ordered. -A new dietary manger was to begin working within the next week. -The dietician with the contracted food service company was contacted today for an LCS menu. -She was unsure as to why the EC was not using this menu spreadsheet. -She planned to ensure the facility would maintain a matching therapeutic diet menu for all physician-ordered therapeutic diets in the future. Observation on 11/21/17 at 3:30 pm of the EC revealed that he received a LCS diet menu signed by a registered dietician from contracted food company.	D 296	Prefix Tag: D 296 Obtained menus for all Therapeutic Diets from Reg. Dietician Upon admission or diet order change, copy of the diet order is provided to the dining manager and the diet spreadsheet is updated by the Administrator. New or changed diet orders are also reviewed during daily stand-up meetings. Diet non-compliance forms completed daily by the dining manager and are submitted to the Administrator for review and reporting to physician(s). New Dining Manager now on board at the community.	11/21/17 On-going On-going 11-27-17

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D 358	Continued From page 19	D 358		
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 administer blood pressure medication as ordered for 1 of 3 sampled residents (Resident #3) regarding holding metoprolol and lisinopril for blood pressure lower than 110/70 or pulse rate lower than 60, and awaiting new orders. The findings are: Review of Resident #3's current FL2 dated 7/06/17 revealed: -Diagnoses included hypertension (high blood pressure) and mild dementia. -A physician order for lisinopril 10 mg one tablet one time a day for hypertension. Hold for blood pressure less than 110/70 or pulse lower than 60, call to notify MD (physician) and await new orders. (Lisinopril is used to treat high blood pressure.) -A physician order for metoprolol tartrate 25 mg one tablet two times a day for hypertension. Hold for blood pressure less than 110/70 or pulse lower than 60, call to notify MD (physician) and	D 358		

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D 358	Continued From page 20 await new orders. (Metoprolol is used to treat high blood pressure and increased heart rate.) Review of Resident #3's September 2017 electronic Medication Administration Records (eMARs) revealed: -Preprinted entries for lisinopril 10 mg one tablet one time a day for hypertension and metoprolol tartrate 25 mg one tablet two times a day for hypertension. Hold for blood pressure less than 110/70 or pulse lower than 60, call to notify MD (physician) and await new orders was included on both orders. -Lisinopril 10 mg one tablet one time a day was documented for administration at 10:00 am daily from 09/01/17 to 09/30/17 (except at 10:00 am on 09/10/17, 09/17/17, and 09/24/17, when resident was out of the facility). -Metoprolol tartrate 25 mg one tablet two times a day was documented for administration at 10:00 am and 5:00 pm daily from 09/01/17 to 09/30/17 (except at 10:00 am on 09/10/17, 09/17/17, and 09/24/17 when resident was out of the facility). Continued review of the September 2017 eMAR revealed: -There was documentation for blood pressure (BP) and pulse values recorded at 10:00 am and 5:00 pm daily from 09/01/17 to 09/30/17 (except at 10:00 am on 09/10/17, 09/17/17, and 09/24/17, when the resident was out of the facility). -There were no pulse rates documented less than 60. -Blood pressure values were documented less than 110/70 on 10 of 57 opportunities in September 2017. -Examples of BP values less than 110/70 and metoprolol and lisinopril should have been held were as follows: on 09/02/17 at 10:00 am- BP was 121/65, on 09/05/17 at 5:00 pm- BP was	D 358		

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D 358	Continued From page 21 136/69, on 09/14/17 at 10:00 am- BP was 113/63, and on 09/28/17 at 5:00 pm- BP was 106/64. Review of Resident #3's October 2017 electronic eMAR revealed: -Preprinted entries for lisinopril 10 mg one tablet one time a day for hypertension and metoprolol tartrate 25 mg one tablet two times a day for hypertension. Hold for blood pressure less than 110/70 or pulse lower than 60, call to notify MD (physician) and await new orders was included on both orders. -Lisinopril 10 mg one tablet one time a day was documented for administration at 10:00 am daily from 10/01/17 to 10/31/17 (except at 10:00 am on 10/09/17, 10/22/17, 10/25/17, and 10/29/17, when the resident was out of the facility). -Metoprolol tartrate 25 mg one tablet two times a day was documented for administration at 10:00 am and 5:00 pm daily 10/01/17 to 10/31/17 (except at 10:00 am on 10/09/17, 10/22/17, 10/25/17, 10/29/17; and 5:00 pm on 10/22/17 and 10/27/17, when the resident was out of the facility). Continued review of the October 2017 eMAR revealed: -Documentation for blood pressure (BP) and pulse values recorded at 10:00 am and 5:00 pm daily from 10/01/17 to 10/31/17 (except at 10:00 am on 10/09/17, 10/22/17, 10/25/17, 10/29/17; and 5:00 pm on 10/22/17 and 10/27/17, when the resident was out of the facility). -There were no pulse rates documented less than 60. -Blood pressure values were documented less than 110/70 on 13 of 56 opportunities in October 2017. -Examples of BP values less than 110/70 and metoprolol and lisinopril should have been held	D 358		

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D 358	Continued From page 22 were as follows: on 10/5 at 10:00 am- BP was 115/66, on 10/05 at 5:00 pm- BP was 117/67, on 10/08 at 10:00 am- BP was 114/66, and on 10/31 at 5:00 pm- BP was 130/60. Review of Resident #3's November 2017 electronic eMAR revealed: -Preprinted entries for lisinopril 10 mg one tablet one time a day for hypertension and metoprolol tartrate 25 mg one tablet two times a day for hypertension. Hold for blood pressure less than 110/70 or pulse lower than 60, call to notify MD (physician) and await new orders was included on both orders. -Lisinopril 10 mg one tablet one time a day was documented for administration at 10:00 am daily from 11/01/17 to 11/20/17. -Metoprolol tartrate 25 mg one tablet two times a day was documented for administration at 10:00 am and 5:00 pm daily from 11/01/17 to 11/20/17 at 10:00 am. Continued review of the November 2017 eMAR revealed: -Documentation for blood pressure (BP) and pulse values recorded at 10:00 am and 5:00 pm daily from 11/01/17 to 11/20/17. -There were no pulse rates documented less than 60. -Blood pressure values were documented less than 110/70 on 17 of 39 opportunities in November 2017. -Examples of BP values less than 110/70 and metoprolol and lisinopril should have been held were as follows: on 11/02/17 at 10:00 am- BP was 137/63, on 11/07/17 at 10:00 am- BP was 95/57, on 10/19/17 at 10:00 am- BP was 166/69, and on 11/19/17 at 5:00 pm- BP was 150/60. Review of Resident #3's record revealed there	D 358		

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D 358	Continued From page 23 were no documented falls or episodes of dizziness or lightheadedness due to low blood pressure. Interview on 11/21/17 at 12:30 pm with the Resident Care Director (RCD) revealed: -The medication aides (MAs) should be taking Resident #3's blood pressure and following the parameters of the order for holding metoprolol and lisinopril until the physician had been notifying the physician for blood pressures less than 110/70 and new order given. -MAs should have been contacting Resident #3's physician regarding instructions for administering Resident #3's blood pressure medications. Interview on 11/21/17 at 1:30 pm with the Administrator revealed: -The RCD would be responsible for reviewing the residents' medication orders and assuring staff were following medication orders. -Resident #3's eMAR and electronic progress notes revealed no documentation for MAs notifying Resident #3's physician for blood pressures less than 110/70 and orders regarding administration of metoprolol and lisinopril for BP less than 110/70 as ordered. -She was not aware MAs were not notifying the physician as ordered and administering metoprolol and lisinopril without the new order. Interview on 11/21/17 at 1:40 pm with a Medication Aide revealed: -The medication aides were supposed to notify the physician when a resident had an order like Resident #3's. -The medication aide on duty called the physician to notify him of low blood pressures according to physicians' orders. -The MA had to add the blood pressure values to	D 358		

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THE TERRACE AT BRIGHTMORE OF SOUTH CHARLC	10225 OLD ARDREY KELL ROAD CHARLOTTE, NC 28277

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D 358	Continued From page 24 the eMAR prior to administering the medication due to the way the order was entered into the eMAR system. -MA staff must have overlooked reading the complete order to hold metoprolol and lisinopril for blood pressure less than 110/70 until the physician replied. -The eMAR system had an electronic progress notes section for staff to document physician notification. -She did not recall if she documented as administered Resident #3's metoprolol and lisinopril when BP values were less than 110/70. Interview on 11/21/17 at 1:50 pm with Resident #3 revealed; -Staff took her blood pressure routinely before administering her medication. -She received her medications, including blood pressure medications, routinely. -She was not aware of the order to notify her physician for certain parameters.. -She had not experienced any episodes of lightheadedness or dizziness that she thought would have been from low blood pressure. Telephone interview on 11/21/17 at 2:10 pm with a representative for Resident #3's physician revealed: -There was not documentation that the facility staff had notified the physician's office for blood pressures less than 110/70. -The physician would have expected the facility to follow the order to notify the office for blood pressure less than 110/70 and hold metoprolol and lisinopril until instructions were given.	D 358	Prefix Tag: D 358 Administrator trained current Med-Techs on following med order parameters. Electronic MAR now has an alert to remind Med-Techs of special physician's ordered parameters of medications. New Resident Care Coordinator will monitor daily using Progress Notes Report and Daily Checklist to ensure compliance and follow up is completed. Received new medication orders, for Resident #3, with new parameters that are more specific for better compliance by Med-Techs. Administrator or RCC will sign-off on all new physician ordered parameters.	11/21/17 12/14/17 On-going 11/29/17 On-going
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060144	A. BUILDING: _____ B. WING _____	11/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 25 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 assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Health Care Personnel Registry checks and other requirements. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to assure all that all fire safety equipment was maintained in a safe and operating condition related to 6 of 10 magnetic door locks in the memory care unit. [Refer to Tag D0105, 10A NCAC 13F .0311(a) Other Requirements (Type B Violation)]. B. Based on observations, interviews, and record reviews, the failed to assure 2 of 4 sampled staff (Staff A and Staff B) had no substantiated findings on the North Carolina Health Care Personnel Registry. [Refer to Tag D0137, 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation)].	D912	Prefix Tag: D 912 Padlock removed from switch covers.	11/21/17
			Installed plastic, break-away padlocks – as approved by DHSR	11/27/17
			DHSR – Construction Section representative on site and tested magnetic locks – confirming that magnetic locks released the doors when the fire alarm pull-box was activated,	11/22/17
			Magnetic locks will be monitored to confirm releasing during monthly fire drill performed by Maintenance Director.	On-going
			HCPR completed for both Staff A & B by Business Office Manager and copies placed in respective personnel files.	11/21/17
			Employee charts audited and HCPR completed and copies in all employee file.	11/23/17
			BOM responsible for all HCPR checks for all employees and new hires, including contracted dining employees. New orientation checklist for contracted dining created and in use.	On-going
			BOM will complete monthly audit of new hires, the last week of each month.	On-going

Jolamadre, LPN 12/18/17