STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060106	A. BUILDING: _____ B. WING _____	R 12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS IN HIGHLAND CREEK	6101 CLARKE CREEK PARKWAY CHARLOTTE, NC 28269

(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 and follow-up survey on 12/04/18-12/05/18.	D 000		
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 to meet the acute health care needs of 1 of 5 sampled residents (Resident #3) with symptoms of a urinary tract infection (UTI). The findings are: Review of Resident #3's current FL2 dated 08/17/18 revealed: -Diagnoses included cerebrovascular accident, hypokalemia, and hypothyroidism. -There was an order for acetaminophen 325mg, one tablet every 4 hours as needed. Review of a physician's order dated 11/29/18 revealed an order to collect a urine specimen via swab for urinary albumin to urinary creatinine (UA/UC) to diagnosis a UTI.	D 273		

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Review of lab report dated 12/01/18 revealed Resident #1 urinalysis was positive for bacteria which indicated a UTI.

Interview with Resident #3 on 12/04/18 at 9:10am revealed:
-The resident had not felt well "the last few days".
-She had lab work completed for a UTI on last week and had to wait five days for the results.
-She had not been given any medication to treat her symptoms.
-Her stomach felt full and she felt an urgency to urinate.

Review of Resident #3's November 2018 Medication Administration Records (MAR) revealed:
-There was an entry for acetaminophen 325mg, one tablet every four hours as needed.
-Acetaminophen 325mg one tablet was documented as administered on 11/29/18 and 11/30/18 at 8:00pm for "complaints of bladder pain"

Review of Resident #3's record revealed there was no documentation that the primary care provider (PCP) had been contacted in regards to the positive results of the UA/UC.

Telephone interview with the second shift medication aide (MA) on 12/05/18 at 11:20am revealed:
-She administered acetaminophen on 11/29/18 and 11/30/18 to Resident #3 because she complained of bladder pain.
-She thought the PCP would have ordered an antibiotic to treat the residents' UTI symptoms when she collected the urine specimen on 11/29/18.
-She thought she sent a fax to the PCP on

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11/30/18 requesting medication to treat symptoms of bladder pain.
-She had not notified the Resident Services Director (RSD) or the Assistant Resident Services Director (ARSD), or any other staff member because she sent a fax to the physician.
-She did not follow-up after 11/30/18 because she did not work on the weekend.
-She thought medication would be ordered for Resident #3 because the PCP "always ordered antibiotics to treat symptoms of UTI".

Review of the facility outgoing fax communications revealed there was no fax communication sent to the PCP office to request medication for symptoms of bladder pain.

Telephone interview with the customer service representative at the PCP's office on 12/05/18 at 11:50am revealed:
-All calls and faxes from the facility were received and entered into their computer system and forwarded to the PCP.
-She was able to review notes from the PCP and recent orders.
-Resident #3 was seen by the Nurse Practitioner (NP) on 11/29/18 and a urine specimen was collected due to symptoms of a UTI.
-The lab results for a positive UTI was received on 12/01/18.
-The NP ordered an antibiotic for Resident #3 on 11/29/18 and sent it to the pharmacy.
-There was no record of a phone call or fax received from the facility requesting medication to treat symptoms of UTI.

Telephone interview with the pharmacist at the contracted pharmacy on 12/05/18 at 11:50am revealed there was no order received from 11/29/18-12/03/18 from the facility or PCP for an

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D 273	Continued From page 3 antibiotic for Resident #3. A second interview with Resident #3 on 12/05/18 at 11:06 am revealed; -She began complaining of bladder pain and an urgency to urinate "all the time" on 11/29/18. -The NP collected her urine on 11/29/18. -The resident thought she would have started antibiotics to help with her symptoms. -The MA gave her Tylenol a few nights to "help me get through the night". -She drank cranberry juice from the dining room to help with the symptoms. -She asked a few MAs about her lab results and any new medications and they informed nothing new had been ordered. -She finally received a response about her lab results when she spoke with the Assistant Resident Service Director (ARSD) on 12/04/18 while passing by in the hallway. -The resident began an antibiotic "this morning" (12/05/18). Interview with the ARSD on 12/05/18 at 9:47am revealed: -She knew Resident #3 was complaining of symptoms related to UTI. -The NP came to the facility to collect a urine specimen. -She did not know if medication had been ordered to help with symptoms of UTI. -Resident #3 told her on 12/04/18 that she was still having symptoms and she told the PCP on 12/04/18 while he was in the facility seeing patients. -Residents were normally treated with antibiotics while lab work was pending to help alleviate symptoms. -She did not realize Resident #3 was not being treated by PCP after complaining of UTI	D 273		

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D 273	Continued From page 4 symptoms. Interview with the Resident Service Director (RSD) on 12/05/18 at 12:38pm revealed: -She did not know Resident #3 was not ordered antibiotics to treat her UTI. -She would expect the MAs to notify her if a resident was complaining of symptoms and a medication had not been ordered. -Resident # 3 should have been placed in the "24 hour report" for the next shift to follow-up on medication to treat UTI symptoms. -Resident #3 could have also been put in the "hotbox" so that she and the ARSD could follow-up. -"We dropped the ball on this and will take responsibility". Interview with the PCP on 12/05/18 at 11:26am revealed: -The NP saw Resident #3 on 11/29/18 to collect urine specimen. -The NP informed him that Resident #3 was ordered an antibiotic but the facility did not receive the order. -Resident #3 should have received an antibiotic to treat her symptoms because "her symptoms would only get worse". -He would have expected the facility to call and request an order if the resident was complaining of symptoms. Interview with the NP on 12/05/18 at 12:45pm revealed: -She saw Resident #3 and collected her urine sample on 11/29/18. -She thought she ordered an antibiotic and sent to the facility on the same day she collected the sample. -She did not know what happened but the	D 273		

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D 273	Continued From page 5 facility/pharmacy did not receive the order and there was no fax confirmation. -She received a call on 12/04/18 from the ARSD stating that Resident #3 was not ordered an antibiotic. -She always treated residents for symptoms and would not have waited on results to order antibiotic. -Resident #3 would have been at risk for urosepsis and confusion if her symptoms were not treated. -She would have wanted the facility to call within one day if an order to treat a UTI was not received and the resident was still complaining of symptoms. Interview with the Administrator on 12/05/18 at 1:00pm revealed: -She did not know the PCP for Resident #3 was not contacted regarding a medication order to treat the UTI. -She expected the staff to follow-up with physician if an order to treat symptoms was not received. -She would expect MAs to also notify the RSD and ARSD about pending treatment so that they could follow-up. -She expected the "hotbox" and "24 hour report" system to be used to communicate with staff that treatment was pending for residents.	D 273		