STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNITY	11230 BALLANTYNE TRACE COURT 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 conducted an annual and follow-up survey on January 14-15, 2019.	D 000		
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 implement orders to obtain a pulse prior to administering a medication for 1 of 1 sampled residents (Resident #1) with pulse parameters. The findings are: Review of Resident #1's current FL2 dated 02/26/19 revealed: -Diagnoses included abdominal aortic aneurysm, hypertension, anxiety, and muscle weakness -An order for labetalol 200mg (used to treat high blood pressure) one tablet three times daily, hold	D 276		

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for systolic blood pressure (SBP) less than 110 or heart rate less than 55.

Review of Resident #1's signed physician's order dated 11/19/19 revealed there was an order for labetalol 200mg 1 tablet three times daily, hold for SBP less than 110 or heart rate less than 55.

Review of Resident #1's November 2019 Medication Administration Record (MAR) revealed:
-There was an entry for labetalol 200mg one tablet three times daily, hold SBP less than 110 or heart rate less than 55 at 9:00am, 2:00pm, and 9:00pm.
-Labetalol 200mg was documented as administered three times daily at 9:00am, 2:00pm, and 9:00pm from 11/01/19-11/30/19.
-The heart rate was documented 4 out of 90 opportunities on 11/02/19, 11/26/19-11/29/19 at 9:00pm.
-Resident #1's blood pressures were obtained as ordered.

Telephone interview with a representative with the facility's contracted pharmacy on 01/15/20 at 11:47am revealed:
-The pharmacy was responsible for printing medications and parameters on the MAR.
-The pharmacy did not print the heart rate parameters in error.
-The facility was responsible for notifying the pharmacy of any MAR errors before the month began.
-The pharmacy noticed the error and updated the December 2019 MAR.

Review of Resident #1's December 2019 MAR revealed:
-There was an entry for labetalol 200mg one

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tablet three times daily, hold SBP less than 110 or heart rate less than 55 at 9:00am, 2:00pm, and 9:00pm.
-Labetalol 200mg was documented as administered three times daily at 9:00am, 2:00pm, and 9:00pm from 12/01/19-12/31/19.
-The heart rate was not documented 23 out of 93 opportunities from 12/01/19-12/31/19.
-Resident #1's heart rate ranged from 60-72.
-Resident #1's blood pressures were obtained as ordered.

Review of Resident #1's January 2020 MAR revealed:
-There was an entry for labetalol 200mg one tablet three times daily, hold SBP less than 110 or heart rate less than 55 at 9:00am, 2:00pm, and 9:00pm.
-Labetalol 200mg was documented as administered three times daily at 9:00am, 2:00pm, and 9:00pm from 01/01/20-01/13/20.
-The heart rate was not documented 4 out of 39 opportunities from 01/01/20-01/13/20.
-Resident #1's heart rate ranged from 62-74.
-Resident #1's blood pressures were obtained as ordered.

Interview with the first shift medication aide (MA) on 01/15/20 at 9:23am revealed:
-She had not documented the pulse on the MAR for November 2019 for Resident #1, "I overlooked it".
-She should have checked the pulse for Resident #1 and recorded it on the MAR.
-In December 2019, "it was an oversight", she forgot to check and record the pulse as ordered.

Interview with a second shift MA on 01/14/20 at 4:16pm revealed:
-In November 2019, she was not taking the pulse

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regularly as there was no space to document the pulse on the MAR.
-She noticed the instructions on the MAR when working towards the end of November 2019 and began checking Resident #1's pulse.
-The pulse not been checked and documented was an "oversight".
-The MARs were checked monthly by a MA and the nurse monthly, "she did not know who it was missed.
-She was should have documented the heart rate on the MAR per the order.
-There was not much space on the MAR to document the blood pressure and the pulse.

Interview with Resident #1 on 01/15/20 at 1:40pm revealed:
-She thought the MAs checked her blood pressure and pulse daily.
-She could not remember how often her pulse was checked by staff.
-She had not experienced any dizziness or fainting episodes.

Interview with the Wellness Nurse (WN) on 01/15/20 at 10:15am revealed:
-She checked the MARs once per month when received from the pharmacy to ensure accuracy.
-She compared the new MAR to the previous month's MAR to ensure orders were listed correctly.
-She had not noticed the pulse parameters was not listed on the MAR for November 2019.
-The Director of Resident Care (DRC) was responsible for reviewing the MARs for any missed documentation or administrations.
-When comparing the old MAR she only reviewed the orders, not the documented administrations.
-There needed to be more space on the MAR for the MA to document the blood pressure and

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pulse.

Interview with the Director of Resident Care (DRC) on 01/15/20 at 10:25am revealed:
-She reviewed all of the residents MARs several times per week to ensure that MAs were documenting properly.
-On the 25th of each month the new MARs were delivered to the facility and it was the WN responsibility to check the MAR to ensure orders were accurate.
-In November 2019, there was no place to document Resident #1's pulse on the MAR.
-"It should have been caught when the MARs were checked after being received from the pharmacy".
-There was nowhere else the pulse was recorded for Resident #1.
-She expected the MAs to document the pulse and hold the medication if the pulse was less than 55.
-She had been checking to make sure the MAR had no holes, however had not noticed that the pulse was missing from the MAR.

Telephone interview with the nurse for Resident #1's primary care provider (PCP) on 01/15/20 at 9:35am revealed:
-The resident was ordered labetalol for high blood pressure.
-The PCP wanted the labetalol to be held if her heart rate was less than 55 to prevent the resident's blood pressure from being too low.
-If the resident's blood pressure was too low, it could result in dizziness or fainting.

Interview with the Administrator on 01/15/20 at 2:00pm revealed:
-MAs were to follow orders as written on the MAR.

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D 276	Continued From page 5 -She expected the MAs, WN, and DRC to check to the MAR to ensure that there was a space to record parameters. -She expected the WN and DRC to check the MARs periodically to ensure MAs were documenting properly on the MAR.	D 276		
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 medications as ordered for 1 of 7 sampled residents (Resident #1) related to a medication used to treat gastroesophageal reflux disease (GERD). The findings are: Review of Resident #1's current FL2 dated 02/26/19 revealed: -Diagnoses included abdominal aortic aneurysm, hypertension, anxiety, and muscle weakness -There was an order for pantoprazole 20mg (used to treat GERD) one tablet daily. Review of Resident #1's signed physician's order dated 10/02/19 revealed:	D 358		

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-There was an order for pantoprazole 40mg one tablet daily.
-Pantoprazole was "likely the major contributor to her cough".

Review of Resident #1's November 2019 Medication Administration Record (MAR) revealed:
-There was an entry for pantoprazole 40mg take one tablet daily at 9:00am.
-Pantoprazole 40mg was documented as administered daily 9:00am from 11/01/19-11/30/19.

Review of Resident #1's December 2019 MAR revealed:
-There was an entry for pantoprazole 40mg take one tablet daily at 9:00am.
-Pantoprazole 40mg was documented as administered daily 9:00am from 12/01/19-12/31/19.

Review of Resident #1's January 2020 MAR revealed:
-There was an entry for pantoprazole 40mg take one tablet daily at 9:00am.
-Pantoprazole 40mg was documented as administered daily 9:00am from 01/01/20-01/13/20.

Review of Resident #1's medications available for administration on 01/14/20 at 4:03pm revealed:
-There was one bubble pack of pantoprazole 20mg on the cart with 19 pills remaining.
-The instructions on the bubble pack was to take one tablet daily.
-The pantoprazole 20mg was dispensed on 01/06/20.
-The original order date listed on the bubble pack was 04/08/19.

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-There was no "directions changed" sticker labeled on the bubble pack.

Interview with a representative from the resident's pharmacy on 01/15/20 at 9:28am revealed:
-The pharmacy received an order dated 04/08/19 for pantoprazole 20mg one tablet daily.
-The pharmacy had not received an order dated 10/02/19 for pantoprazole 40mg one tablet daily.
-The pharmacy dispensed 30 tablets of pantoprazole 20mg on 11/20/19, 12/10/19, and 01/06/20.
-The tablets dispensed were for a one-month supply, if two pills were given daily, the bubble pack would not last the entire month.

Interview with the facility's contracted pharmacy on 01/15/20 at 11:47am revealed:
-Resident #1 used a different pharmacy, but they printed the MARs for the facility.
-The pharmacy dispensed medications for Resident #1 as requested by the facility when needed.
-The pharmacy had never dispensed pantoprazole 40mg for Resident #1.

Interview with the first shift medication aide (MA) on 01/15/20 at 9:23am revealed:
-She administered Resident #1 one tablet of pantoprazole every morning.
-She had not noticed the bubble pack included pantoprazole 20mg tablets.
-She did not realize she had been giving Resident #1 the wrong dose of pantoprazole, "it was an oversight".
-"I should be giving her two tablets".
-She did not match the MAR with the bubble pack to ensure the correct dose was administered.

Interview with Resident #1 on 01/15/20 at 1:40pm

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revealed:
-She received her medications daily.
-She did not experience reflux after eating.
-She continued to experience a cough after drinking water.

Interview with the Wellness Nurse (WN) on 01/15/20 at 10:15am revealed:
-When new orders were received, the MA, and herself were responsible for faxing the orders to the pharmacy.
-New orders for Resident #1 had to be faxed to her preferred pharmacy and the facility's contracted pharmacy to be entered onto the MAR.
-The order for Resident #1's pantoprazole was "probably" not sent to Resident #1's preferred pharmacy.
-The pharmacy should be contacted to ensure that a new order was received after it was faxed.
-Whoever received the order should have faxed to both pharmacies, "that was an error".
-There were times when the MAs were not checking to make sure they sent an order to the correct pharmacy.
-She tried to complete cart audits quarterly.

Interview with the Director of Resident Care (DRC) on 01/15/20 at 10:25am revealed:
-The MA and WN were responsible to faxing new orders to the pharmacy.
-Resident #1's order had to be faxed to two pharmacies.
-She expected the MAs and the WN to complete cart audits weekly to catch any errors.
-The MAs, WN, and DRC were all responsible for faxing the order and ensuring the primary pharmacy and facility pharmacy received the order.
-"We should have called to verify it was received".

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D 358	Continued From page 9 -The MAs should have been given two tablets of pantoprazole 20mg. Interview with the Administrator on 01/15/20 at 2:00pm revealed: -MAs were to follow orders as written on the MAR. -She expected the MAs and Licensed Practical Nurses (LPNs) to fax orders to both pharmacies. -Cart audits should be done monthly by the WN and DRC to catch any errors. Attempted interview with Resident #1's allergy and immunology specialist on 01/15/20 at 9:42am was unsuccessful.	D 358		