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
	HAL060087	A. BUILDING: _____ B. WING _____	R 12/18/2019

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 a follow-up survey 12/17/19-12/18/19.	{D 000}	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 Charlotte Square 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 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the assessed needs for 1 of 7 sampled residents (Resident #5) related to falls. The findings are: Review of the facility's Fall policy revealed post-fall interventions included monitoring the resident and placing the resident on "alert charting/hot box charting" for 72 hours following a fall, there was no additional information related to increased supervision of residents with falls. Review of Resident #5's current FL-2 dated 08/06/19 revealed: -Diagnoses included dementia, cerebral vascular	{D 270}		

Reviewed and acknowledged.
QAPR 1/30/2020

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{D 270}	Continued From page 1 accident, hypertension, and chronic pain. -Resident #5 was intermittently disoriented, semi-ambulatory, and required staff assistance with bathing and dressing. Review of Resident #5's care plan dated 09/11/19 revealed: -Resident #5 needed limited staff assistance with transfers and ambulation. -There was no documentation of updates, change of condition, or increased supervision. Review of a consultation note from Resident #5's primary care provider (PCP) on 08/16/19 revealed the resident was "progressing, 5 falls in last week, may need transfer to memory care, poor safety awareness". Review of a consultation note from Resident #5's PCP on 08/30/19 revealed the resident "remains high fall risk, better suited for memory care. Needs increased supervision, continue physical therapy and occupational therapy (PT/OT)". Review of Resident #5's progress notes revealed: -On 09/24/19 (time unknown), "Resident was sat on the floor due to her feet being weak", no injuries documented. There was no documentation staff increased supervision of the resident in response to her fall. -On 09/29/19 at 7:35am, "Resident was observed on the floor at bedside conscious and alert sitting she lost her balance and fell transferring from the bed to her wheelchair", no injuries documented. There was no documentation staff increased supervision of the resident in response to her fall. -On 10/07/19 at 6:55am, "Resident was observed on the floor at bedside, conscious and alert, she was trying to get into wheelchair from the bed, resident had no injuries". There was no	{D 270}	Tag: D 270 1. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 2. The Wellness Director in-serviced staff on accurately reading and responding to individualized service plans to ensure residents are receiving the correct supervision needs based on current symptoms. New shift reports have been developed for staff to provide important changes to oncoming shift such as falls, infections, abnormal vital sign readings, etc. 3. The Wellness Director, Executive Director or designee will conduct daily audits for the next 6 months to ensure care plans reflect the appropriate supervision need. 4. Completion: January 30, 2020	

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{D 270}	Continued From page 2 documentation staff increased supervision of the resident in response to her fall. -On 10/17/19 at 2:45am, "Resident was observed on the floor at bedside, conscious and confused calling herself stupid for trying to get up and walk, she was observed during rounds by staff, emergency call light was not activated, there was no apparent injuries". There was no documentation staff increased supervision of the resident in response to her fall. -On 10/18/19 at 10:15pm, "Resident observed on floor on right side of bed between wall and bed, she was complaining of a great deal of pain, stated she hit her head, all sheets were in the floor under the resident, resident sent out due to extent of pain and possible head injury". There was no documentation staff increased supervision of the resident in response to her fall. -On 10/20/19 during 7am-3pm shift, "Resident was found on the floor bedside stated she slid off bed trying to adjust herself to watch tv, no injuries or complaints of pain". There was no documentation staff increased supervision of the resident in response to her fall. -On 11/02/19 at 9:40am, "Resident observed sitting on the floor leaned up against her bed eating an oatmeal cake and looking through a magazine, no complaints of any pain or injury". There was no documentation staff increased supervision of the resident in response to her fall. Review of a consultation note from Resident #5's PCP on 10/01/19 revealed the resident "had a fall with abrasion to right lower extremity, the abrasion was cleaned and covered by staff, patient reminded to ask for assistance with transfer to prevent future falls". Review of a consultation note from Resident #5's PCP on 10/18/19 revealed the resident "continue	{D 270}		

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{D 270}	Continued From page 3 PT, discussed fall prevention, would fare better in memory care with increased patient supervision. Family holding off at this time". Interview with the Wellness Director (WD) on 12/18/19 at 12:11pm revealed: -Personal care aides (PCAs) and Medication Aides (MAs) were responsible for completing rounds and checking on all residents every 2 hours. -Increased supervision would be every 30 minutes to one hour. -Residents who required increased supervision would have a task listed as "other task: supervision" on the activities of daily living (ADL) report for personal care aides (PCAs) to know that increased supervision is needed. -The computer system was new and she was still learning how to update tasks. -Supervision waould be added as an task when the residents required increased supervision after multiple falls. Interview with the Wellness Director (WD) on 12/18/19 at 1:50pm revealed: -She did not know Resident #5 fell on 09/24/19, 10/07/19, and 10/18/19. -She was not able to find an incident report completed on 09/24/19, 10/07/19, or 10/18/19. -After the falls she was aware of, she instructed staff to check on Resident #5 every hour. -If incident reports were not completed, she would have no knowledge of the fall and the resident could not be included in the "hot box charting". -Hot box charting included residents being included in a red box for staff to monitor every shift for 3 days for changes in health status. -She expected the medication aides (MAs) to complete incident reports on the same day the fall occurred and give her a copy so that she could	{D 270}		

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{D 270}	Continued From page 4 be aware. Review of Resident #5's record from 09/20/19-12/18/19 revealed: -Resident #5 experienced 7 unwitnessed falls from 09/24/19-11/02/19. -There was no documentation staff increased supervision of Resident #5 in response to her falls. Review of Resident #5's ADL report printed 12/18/19 revealed "other task: supervision" was not listed for the resident. Interview with a first shift personal care aide (PCA) on 12/18/19 at 12:30pm revealed: -She checked on Resident #5 at least every two hours. -She had not been instructed to check on Resident #5 more frequently than 2 hours. -When she went in Resident #5's room to check on the resident, she made sure the pathways to the door and bathroom were kept clear of obstacles. -She was told by the medication aides (MA) to keep Resident #5's wheelchair away from the resident's reach to prevent her from getting up independently to transfer to the wheelchair. -The WD or Administrator had not given her any specific instruction regarding increased supervision for Resident #5. Interview with a second shift PCA on 12/18/19 at 3:45pm revealed: -She was not told Resident #5 had recent falls. -She checked on all the residents during her shift walking the hallways when she was not busy doing other things. -She answered Resident #5's call bell if she used it.	{D 270}		

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{D 270}	Continued From page 5 -She did not check on Resident #5 more than every hour. -She was not told to check on Resident #5 more frequently than every hour. Interview with first shift medication aide (MA) on 12/18/19 at 12:45pm revealed: -She knew Resident #5 had recently fallen more than one time in the last month. -She was told MAs were supposed to check on residents with falls every shift, and document it in the progress notes in the resident's record. -When she checked on Resident #5, she forgot to document it in Resident #5's progress notes because she must have been too busy. Telephone interview with a 3rd shift PCA on 12/18/19 at 3:11pm revealed: -She kept "an eye" on resident who fell frequently. -She made rounds throughout the night and checked on each resident every 2 hours. -If a resident required increased supervision, she checked on them every 1.5 hours. -She received no instructions from management to increase supervision for any resident. -She would receive instruction from the MA to provide any additional supervision. -She had not received any specific instruction to increase supervision for Resident #5. -She checked on all residents throughout the night. Interview with Resident #5's PCP on 12/17/19 at 3:00pm revealed: -His last visit with Resident #5 was in October 2019. -The family opted for Resident #5 not to be placed in memory care. -He would suggest the family hire a sitter, there was only so much supervision that could be	{D 270}		

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{D 270}	Continued From page 6 provided in an assisted living facility. -Resident #5 would benefit from increased supervision in memory care to prevent injury. -He had been notified of all falls for Resident #5. -Resident #5 would need increased supervision for proper safety. Interview with the WD on 12/18/19 at 4:40pm revealed: -After each fall, the MA supervisor was to document 3 days for all three shifts to identify any changes in health, skin, or anything out of the ordinary for any resident in the hot box charting. -She educated the staff to always complete incident reports and hot box charting for all residents with falls. -She ensured documentation was being complete. -She noticed "recently" that documentation had not always been completed and she was re-educating the staff. -She was not aware of all of Resident #5's falls because incident reports were not completed for all of the falls. -She was not able to go through the progress notes for every resident every day. -She instructed all shift supervisors to increase supervision to every hour for Resident #5. -The Resident Care Coordinator was responsible for making sure all activities daily living (ADL) tasks were listed for each resident, however the computer system was new and they were still learning how to update the tasks. -She had several conversations with the family regarding Resident #5 going to memory care and, the family refused. -She and the Administrator had personally been going in the room to check on Resident #5 throughout the day when they worked.	{D 270}		

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{D 270}	Continued From page 7 Interview with the Administrator on 12/18/19 at 4:51pm revealed: -She expected an incident report to be completed by the MAs after each fall and given to the WD in person, or by sliding it under her door. -She and the WD have explained several times that incident reports needed to be completed. -Resident #5 had received PT and they had worked with the family to minimize falls. -Recently, Resident #5's wheelchair had been moved out of sight to prevent her from falling out of her bed. -She discussed with the family increased supervision and the family agreed to come and in the evening and provide additional supervision. -She had not received an FL2 from the PCP to move Resident #5 to memory care, therefore she remained in assisted living. -PCAs and MAs were told by her and RCC to check on Resident #5 every hour. -She expected after each fall, the resident was to go into the "red hot box", she expected staff to pay close attention and document any changes with the resident on each shift for 3 days. -She discussed hiring a sitter with Resident #5's family, however they declined. -She discussed memory care placement with Resident #5's family , however they declined. Based on record review, observation, and interview it was determined that Resident #5 was not interviewable.	{D 270}		
{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.	{D 273}		

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{D 273}	Continued From page 8 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 2 of 7 sampled residents (Resident #5 and Resident #6) with blood pressure measurements outside of ordered parameters. The findings are: 1. Review of Resident #5's current FL-2 dated 08/06/19 revealed: -Diagnoses included dementia, cerebral vascular accident, hypertension, and chronic pain. -There was an order to check blood pressure (BP) daily. Review of Resident #5's record revealed there was no signed physician's order for blood pressure parameters since the most recent FL2 was completed. Review of Resident #5's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check and record BP scheduled for 8:00am and notify the primary care provider (PCP) if SBP was above 180 or less than 100 or the DBP was above 100 or less than 50. -The original order date for the parameter was documented as 10/31/18. -One of thirty BP readings were outside of the	{D 273}	Tag: D 273 1. Resident 6 physician is being notified when the blood pressure measurements are outside the ordered parameter. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Wellness Director or designee will ensure that follow-up occurs as ordered by the physician or as needed. 4. The Wellness Director or designee will conduct monthly reviews of all MARs requiring blood pressure and blood sugar checks. The Registered Nurse will verify that the physician has been contacted if blood pressure or blood sugar is outside of the ordered parameter. A standard fax sheet has been developed for the Medication Aide to fax the physician. Completion: January 30, 2020	

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{D 273}	Continued From page 9 ordered parameters. -On 10/05/19, the BP reading was 184/82. -There was no documentation Resident #5's PCP was contacted on 10/05/19. Review of Resident #5's November 2019 eMAR revealed: -There was an entry to check and record BP scheduled for 8:00am and notify the PCP if SBP was above 180 or less than 100 or the DBP was above 100 or less than 50. -The original order date for the parameter was documented as 10/31/18. -Three of twenty-nine BP readings were outside of the ordered parameters. -On 11/13/19, the BP reading was 194/102. -On 11/23/19, the BP reading was 179/114. -On 11/24/19, the BP reading was 171/109. -There was no documentation Resident #5's PCP was contacted on 11/13/19, 11/23/19, or 11/24/19. Review of Resident #5's December 2019 eMAR revealed: -There was an entry to check and record BP scheduled for 8:00am and notify the primary care provider (PCP) if SBP was above 180 or less than 100 or the DBP was above 100 or less than 50. -The original order date for the parameter was documented as 10/31/18. -One of eighteen BP readings were outside of the ordered parameters. -On 12/12/19, the BP reading was 169/109. -There was no documentation Resident #5's PCP was contacted on 12/12/19. Review of Resident #5's progress notes revealed no documentation the PCP had been notified of any BP outside of ordered parameters in October, November, or December 2019.	{D 273}		

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{D 273}	Continued From page 10 Interview with a medication aide (MA) on 12/18/19 at 5:30pm revealed: -She had recorded Resident #5's blood pressure reading on 11/13/19, 11/23/19, 11/24/19, and 12/12/19. -She did not realize Resident #5 had an order to check her BP daily and notify the PCP if the BP was outside of the ordered parameters. -It was the MA's responsibility to contact the PCP via fax and document the contact in the resident's progress notes. -If she had notified the PCP, she would have documented the contact in Resident #5's progress notes. Interview with Resident #5's PCP on 12/17/19 at 3:00pm revealed: -Resident #5's BP was to be checked daily and he was to be contacted if the SBP was above 180 or less than 100 or the DBP was above 100 or less than 50. -He expected staff to contact him immediately if BPs were outside of the parameters so that he could make any necessary changes. -He had not been contacted about any of Resident #5's BPs that were outside of parameters. -He did not see any documentation in his computer system, where the facility contacted him or his co-worker regarding high blood pressures. Interview with the Wellness Director (WD) on 12/18/19 at 4:40pm revealed: -She found out last week that the provider had not been contacted regarding BPs outside of the parameters for residents. -She spoke with MAs last week regarding the importance of contacting the doctor when BPs are outside of parameters.	{D 273}		

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{D 273}	Continued From page 11 -The Administrator was also notified, and had been working with her to notify physicians of BPs that were outside of parameters. -MAs were responsible and expected to notify the physician the same day via fax that BPs were outside of the parameters and document in progress notes. -The Administrator created a standard form on 12/17/19 for all MAs to use when contacting the PCP. -Prior to 12/17/19, there was no standard form, MAs were expected to write a note to the physician and send via fax. Interview with the Administrator on 12/18/19 at 4:51pm revealed: -She expected MAs to follow parameters as ordered and contact the physician. -The order for Resident #5 was listed on the eMAR and MAs should have been notifying the PCP the same day the BP was outside of the parameters. -She and the WD had been working with MAs by consistently educating the importance of notifying the PCP. 2. Review of Resident #6's FL-2 dated 10/31/19 revealed: -Diagnoses included bradycardia, hypertension, hyperlipidemia, pacemaker, coronary artery disease. -An order for blood pressure to be checked daily. Review of Resident #6's resident record revealed: -A physician's order dated 08/07/19 for Resident #6's blood pressure to be checked daily and to notify the physician if Resident #6's systolic blood pressure was above 160/100 or below 100/70. -There was no documentation of Resident #6's physician being notified of systolic blood pressure	{D 273}		

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{D 273}	Continued From page 12 readings above 160 or below 100 between 12/05/19 and 12/12/19. Review of Resident #6's December 2019 electronic medication administration (eMAR) record revealed: -There was an entry for blood pressure checks once daily and to notify physician for systolic greater than 160/100 or less than 100/70. -An entry dated 12/05/19 was documented for Resident #6's with a blood pressure reading of 162/70. -An entry dated 12/08/19 was documented for Resident #6's with a blood pressure reading of 162/75. -An entry dated 12/12/19 was documented for Resident #6's with a blood pressure reading of 169/67. -There was no documented communication of Resident #6's blood pressure reading on 12/05/19, 12/08/2019, or 12/12/19 with Resident #6's physician. Interview with Resident #6's physician's nurse on 12/18/19 at 11:00am revealed: -Resident #6 had a history of coronary artery disease and had a pacemaker. -Resident #6 had an order for her blood pressure to be checked daily with parameters for the facility staff to contact the physician if Resident #6's systolic blood pressure was above 160/100 or below 100/70. -The physician was not aware of Resident #6's blood pressures being outside the ordered parameters. -The physician had no record of facility staff reporting Resident #6's blood pressure readings were outside ordered parameters until 12/17/19. -The physician expected facility staff to communicate Resident #6's blood pressure	{D 273}		

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 _____	R 12/18/2019

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 273}	Continued From page 13 readings at least weekly to her if Resident #6's systolic blood pressure was above 160/100 or below 100/70. -If the physician had been aware of Resident #6's systolic blood pressure was above 160/100 or below 100/70, the physician would have reassessed Resident #6's medication orders. Interview with a medication aide (MA) on 12/17/19 at 12:45pm revealed: -She was responsible for obtaining Resident #6's blood pressure daily. -She documented Resident #6's blood pressure results on the eMAR. -Resident #6's physician had ordered the facility to report Resident #6's blood pressure readings if the systolic blood pressure was above 160/100 or below 100/70. -She was responsible for sending a facsimile to Resident #6's physician if Resident #6's systolic blood pressure reading was above 160/100 or below 100/70. -She had recorded Resident #6's blood pressure reading as 162/70 on 12/05/19. -She did not send a facsimile or call Resident #6's physician regarding Resident #6's 12/05/19 blood pressure reading of 162/70. -She did not think Resident #6's December 2019 blood pressure readings had been communicated to the PCP as of 12/17/19. Interview with another MA on 12/18/19 at 10:01am revealed: -She was responsible for obtaining Resident #6's blood pressure daily. -She documented Resident #6's blood pressure results on the eMAR. -Resident #6's physician had ordered the facility to report Resident #6's blood pressure readings if the blood pressure was outside of the transcribed	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 273}	Continued From page 14 blood pressure parameters on the eMAR but did not recall the exact blood pressure parameters for Resident #6. -She was responsible for sending a facsimile or call Resident #6's physician if Resident #6's systolic blood pressure reading was above or below Resident #6's blood pressure parameters. -She had recorded Resident #6's blood pressure reading as 162/75 on 12/08/19 and 169/67 on 12/12/19. -She did not send a facsimile to Resident #6's physician on or about 12/08/19 or 12/12/19 to report Resident #6's blood pressure readings on those days. Interview with the Wellness Director (WD) on 12/18/19 at 11:10am revealed: -Resident #6 had an order for her blood pressure to be checked daily and to notify Resident #6's physician if Resident #6's systolic blood pressure was above 160/100 or below 100/70. -Resident #6's blood pressure readings were documented on the eMAR. -She expected MAs to perform blood pressure checks, document Resident #6's blood pressure results on the eMAR, and notify Resident #6's physician if Resident #6's systolic blood pressure was above 160/100 or below 100/70. -MAs were expected to send a facsimile to Resident #6's physician immediately with a systolic blood pressure reading above 160/100 or below 100/70. -Facsimiles were kept in resident records. -There was no documentation of notifying Resident #6's physician of the systolic blood pressure readings on or about 12/05/19, 12/08/19, or 12/12/19 until 12/17/19. Interview with the Administrator on 12/18/19 at 5:00pm revealed:	{D 273}		

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
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{D 273}	Continued From page 15 -MAs were responsible for completing resident blood pressure readings and documenting them on the eMAR. -She expected MAs to notify Resident #6's physician if Resident #6's systolic blood pressure was above or below the physician ordered blood pressure parameters. -She was not aware MAs had not notified Resident #6's PCP of BPs that were outside parameters.	{D 273}		