STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060098	A. BUILDING: _____ B. WING _____	02/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOTT'S MANOR 2	10215 CONNELL ROAD CHARLOTTE, NC 28227

(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
C 000	Initial Comments `The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and follow-up survey on February 17, 2020.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff A and C) were tested for tuberculosis (TB)	C 140		

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C 140	Continued From page 1 disease in compliance with control measures adopted by the Commission for Public Health. The findings are: 1. Review of Staff C's personnel record revealed: -There was no documentation in Staff C's personnel record of the date of hire. -There was no documentation in Staff C's personnel record of a first step or a second step TB skin test or chest X-ray. Interview with Staff C on 02/17/20 at 2:35pm revealed: -She was a Registered nurse (RN). -She had been working for the past year at the facility on an "as needed" (PRN) basis. -Her duties included checking off staff for Medication Aide (MA) Skills and Licensed Health Professional Support (LHPS) competency, staff training for the Infection Control and she administered medications to the residents as needed. -She was not sure if or when she had her last TB skin test. -The record of immunizations should be in her personnel file. Interview with the Office Manager on 02/17/20 at 4:20pm revealed she did not have any additional personnel information in her records for Staff C. Interview with the Administrator on 02/17/20 at 5:10pm revealed: -Staff C had been working as needed (PRN) at the facility. -Her duties included checking off staff for Medication Aide (MA) Skills and Licensed Health Professional Support (LHPS) competency, staff	C 140		

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C 140	Continued From page 2 training for the Infection Control and she administered medications to the residents as needed. -She was hired this week, part-time twice a week, to review the Medication Administration records (MARS), to perform cart audits and review the physician orders. -He did not know why there was only the Health Care Personnel Registry and Cardiopulmonary Resuscitation documentation in Staff C's personnel file. -He was sure the additional requested documentation was somewhere in the business files. -He thought all the personnel records were up to date. -The Office Manager was responsible for the personnel files.	C 140		
C 141	10A NCAC 13G .0406 (1) Other Staff Qualification 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (1) have a job description that reflects actual duties and responsibilities and is signed by the administrator and the employee; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure a job description that reflected actual duties and responsibilities, signed by the Administrator and the employee for the current facility, and no documentation of a criminal background check or a drug screen test,	C 141		

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C 141	Continued From page 3 were completed for 1 of 3 sampled staff (Staff C). The findings are: Review of Staff C's personnel record revealed: -There was no documentation in Staff C's personnel record of the date of hire. -There was no documentation of a job description signed by the Administrator and the employee in Staff C's personnel record. -There was no documentation of drug test results in Staff C's personnel record. -There was no documentation of consent or results of a criminal background test. Interview with Staff C on 02/17/20 at 2:30pm revealed: -She was a Registered Nurse and had been employed by the facility on an "as needed" basis (PRN). -She did not remember signing a job description upon hire. -She thought she had a drug screening, but did not remember when. -She did not remember signing a consent form for a criminal background check. -She only worked as needed and performed whatever functions the facility needed at the time. -Her duties included Medication Aide (MA) Skills check off, Infection Control training, Licensed Health Professional Support (LHPS) check off for staff and she administered medications to the residents as needed. Interview with the Office Manager on 02/17/20 at 4:20pm revealed she did not have any additional personnel information in her records for Staff C. Interview with the Administrator on 02/17/20 at 5:10pm revealed:	C 141		

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C 141	Continued From page 4 -Staff C had been working as needed at the facility. -Her duties included MA Skills check off, Infection Control training, LHPS check off for staff and she administered medications to the residents as needed. -She was hired this week, part-time twice a week, to review the Medication Administration Records (MARS), to perform cart audits and review the physician orders. -He did not know why there was only the Health Care Personnel Registry and Cardiopulmonary Resuscitation documentation in Staff C's personnel file. -The Office Manager was responsible for the personnel file. -All the paperwork for the staff should be in their personnel file. -He was sure it was somewhere in the business files.	C 141		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure physician orders were implemented for 1 of 3 sampled residents related to orders for oxygen and	C 249		

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C 249	Continued From page 5 weights (Resident #2). The findings are: 1. Review of Resident #2's current FL2 dated 12/09/19 revealed there were no diagnoses listed. a. Review of Resident #2's current FL2 dated 12/09/19 revealed there was an order for oxygen 1-2 Liters as needed (PRN) when the oxygen saturation was below 93%. Review of Resident #2's physician's order dated 12/09/19 with written instructions for oxygen delivered by nasal canula 1-2 Liters, PRN, to keep oxygen saturation between 93-98%. Review of Resident #2's Medication Administration Record (MAR) for December 2019 revealed: -There was no entry to prompt the staff to obtain Resident #2's oxygen saturation levels and none were recorded. -There was no documentation Resident #2 was administered oxygen as needed. Review of Resident #2's MAR for January 2020 revealed: -There was no entry to prompt the staff to obtain Resident #2's oxygen saturation levels and none were recorded. -There was no documentation Resident #2 was administered oxygen as needed Review of Resident #2's MAR for February 2020 revealed: -There was no entry to prompt the staff to obtain Resident #2's oxygen saturation levels and none were recorded. -There was no documentation Resident #2 was administered oxygen as needed.	C 249		

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C 249	Continued From page 6 Interview with the facility's Registered Nurse (RN) on 02/17/20 at 2:00pm revealed: -She thought the Medication Aides (MAs) were not taking Resident #2's oxygen saturation levels because there was no separate physician order instructing them to take the oxygen levels. -She did not know why the order was not clarified with the prescribing physician. -She did not know why the range of 1-2 liters of oxygen had not been clarified. Interview with the Administrator on 02/17/20 at 5:10pm revealed he did not know the MAs were not taking Resident #2's oxygen saturation levels, and did not know if she needed oxygen. b. Review of Resident #2's physician's order dated 12/09/19 revealed instructions to check Resident #2's weight daily. Review of Resident #2's vital sign log sheet for December 2019 revealed the weights were not documented 17 times out of 22 opportunities from 12/11/2019 through 12/31/2019. Review of Resident #2's vital sign log sheet for January 2020 revealed the weights were not documented 17 times out of 31 opportunities from 01/01/2020 through 01/31/2020. Review of Resident #2's vital sign log sheet for February 2020 revealed the weights were not documented 9 times out of 16 opportunities from 02/01/2020 through 02/16/2020. Interview with a Medication Aide (MA) on 02/17/2020 at 2:30pm revealed: -She was aware that Resident #2 had an order to take her weight daily.	C 249		

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C 249	Continued From page 7 -She felt Resident #2 was hard to weigh because the resident could not stand up and this might account for staff not taking weights as ordered. -The scale used to weigh a resident in a wheelchair was located in the "other building" (next door) and was not accurate. Interview with the RN on 02/17/20 at 2:10pm revealed: -She did not have any directive from the physician regarding parameters or notification of weight gain or loss for Resident #2. -She did not know why Resident #2 was getting weighed daily. -The order should be clarified with the physician. -The MAs should be following the order to weigh Resident #2 daily. -If there was a problem due to her level of ambulation, the Administrator and the physician should be notified. Interview with the Administrator on 02/17/20 at 5:10pm revealed: -It was the responsibility of the MAs to follow physician orders as written. -It was the responsibility of the MAs to clarify orders with the physician when needed. -He did not know the MAs were not taking Resident #2's daily weights due to the difficulty in her ambulation. -The RN he hired would be reviewing the orders and the MARS to ensure medications and treatments were implemented as ordered. Based on observations and record review it was determined Resident #2 was not interviewable.	C 249		
C 315	10A NCAC 13G .1002(a) Medication Orders	C 315		

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C 315	Continued From page 8 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify a treatment order for 1 of 3 sampled residents (Resident #1) for the correct liter flow for oxygen administration. Review of Resident #1's current FL2 dated 12/09/19 revealed: - Diagnoses included atrial fibrillation, coronary artery disease (CAD), hypertension and vascular dementia. - There was an order for oxygen 2 Liters(L) - 4L through nasal canula (NC) as needed (PRN) for shortness of breath (SOB). Review of Resident #1's Medication Administration Record (MAR) for January 2020 revealed: -There was an entry for oxygen 2L-4L NC PRN for SOB. -There was no documentation oxygen had been administered from 01/01/20 through 01/31/20.	C 315		

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C 315	Continued From page 9 Review of Resident #1's MAR for February 2020 revealed: -There was an entry for oxygen 2L-4L NC PRN for SOB. -There was no documentation oxygen had been administered from 02/01/20 through 02/17/20. Interview with the facility's Registered Nurse (RN) on 02/17/20 at 2:00pm revealed: -Resident #1 ambulated in her wheelchair and could transfer with the assistance of one person. -She worked as needed (PRN), and had not observed Resident #1 short of breath during those times. -There was no documentation in the progress notes regarding Resident #1's shortness of breath. -However, the MAs would have to decide for themselves, based on the order, what liter flow of oxygen to administer if Resident #1 was short of breath. -Resident #1's oxygen order needed to be clarified by the physician as to the specific liter flow if needed for shortness of breath. Interview with Resident #1's Hospice RN on 02/17/20 at 12:45pm revealed: -He was the primary Hospice nurse for Resident #1. -Resident #1 had an order for oxygen as needed for shortness of breath, 2L-4L. -He had not observed Resident #1 to be short of breath when he visited her. -He relied on the facility to alert him to any changes in behavior. -He could not comment on the correct liter flow of oxygen since the hospice physician had not prescribed the order. Interview with the medication aide (MA) on	C 315		

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C 315	Continued From page 10 02/17/20 at 3:35pm revealed: -She did not work in facility #2 often. -She had not observed Resident #1 short of breath when she had worked there. -She did not know what liter flow of oxygen she would administer if Resident #1 was short of breath. -She "guessed" she would start at 1 liter and keep increasing the liter flow if she was still short of breath. -She thought the order should be clarified. -The MAs were responsible for clarifying medication and treatment orders. -She did not know if anyone reviewed the orders or reviewed the MARS. Interview with the Administrator on 02/17/20 at 5:10pm revealed: -It was the responsibility of the MAs to clarify orders with the physician when needed. -Oxygen orders should not have a range of 2L-4L. -It was his expectation orders received from a physician should not have a range and if they did the orders should be clarified. -He had hired a Registered Nurse this week to oversee orders and the MARS. Based on observation, record review and interviews it was determined Resident #1 was not interviewable.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments	C 330		

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C 330	Continued From page 11	C 330		

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 3 sampled residents (Resident #1) including a blood thinner (used to reduce the risk of stroke), scheduled for twice a day.

The findings are:

1. Review of Resident #1's current FL2 dated 12/11/19 revealed:
-Diagnoses included atrial fibrillation, coronary artery disease (CAD), hypertension and vascular dementia.
-There was an order for Eliquis 2.5mg twice daily, used to reduce the risk of stroke.

Review of Resident #1's February 2020 Medication Administration Record (MAR) revealed :
-There was an entry for Eliquis 2.5mg tablet to be administered twice daily at 9:00am and 7:00pm.
-Eliquis 2.5mg was documented as administered daily at 9:00am from 02/01/20 through 02/17/19.
-Eliquis 2.5mg was documented as administered daily at 7:00pm from 02/01/20 through 02/16/19.

Observation of Resident #1's medications on hand on 02/17/20 at 1:20pm revealed Eliquis 2.5mg was not available for administration.

Interview with the medication aide (MA) on

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C 330	Continued From page 12 02/17/20 revealed: -She usually worked on 2nd shift and was not as familiar with the morning medication routine. -She had administered Resident #1's medications this morning. -She had documented the administration of Eliquis to Resident #1 so "she must have given it to her." -She thought the Eliquis tablets had been ordered from the pharmacy and would be in the facility this evening. -She could not produce documentation Resident #1's Eliquis had been requested for a refill through the pharmacy. Interview with the second shift MA on 02/17/20 at 3:35pm revealed: -She did not usually work as a MA in this facility. -She had administered medications to Resident #1 on 02/15/20 and 02/16/20. -She did not specifically remember administering the Eliquis tablet to Resident #1. -She did not remember any medications during the morning medication pass that needed to be refilled. -The facility was on a cycle fill medication supply. -If a medication had been completed before the next month's batch arrived, the MAs contacted the pharmacy and requested a refill. -She had not contacted the pharmacy for a refill order for Resident #1's Eliquis. Telephone interview with the pharmacist at the facility's contracted pharmacy on 02/17/20 at 3:42pm revealed: -Resident #1's medication profile listed Eliquis 2.5mg, administered twice daily, to be an active order. -On 12/09/19, 30 tablets of Eliquis 2.5mg were dispensed for Resident #1, as a 15 day supply.	C 330		

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C 330	Continued From page 13 -On 12/26/19, 30 tablets of Eliquis 2.5mg were dispensed for Resident #1, as a 15 day supply. -On 01/13/20, 30 tablets of Eliquis 2.5mg were dispensed for Resident #1, as a 15 day supply. -On 01/30/20, 30 tablets of Eliquis 2.5mg were dispensed for Resident #1, as a 15 day supply. -There was a request from the facility today, 02/17/20, for Eliquis 2.5mg to be refilled and delivered as soon as possible. -Based on the fill history, Eliquis tablets would have been completed on 02/14/20. Review of the facility's Medication Administration Policy revealed: -The contracted pharmacy delivered standard routine medications on the 15th of every month. -If an emergency medication was needed, the medication aide (MA) contacted the on call pharmacist and the medication would be called into one of their back up pharmacies. -The MA would arrange for a family member, other staff or Administrator to pick up the medication and deliver it to the facility. Interview with the Registered Nurse (RN) consultant on 02/17/20 at 11:00am revealed: -She had been working as needed and her duties included Medication Aide (MA) Skills check off for the staff and she administered medications to the residents as needed. -She did not know Resident #1 did not have Eliquis 2.5mg tablet available for administration. -She was only on the medication cart if there were staff a call outs. -It was the MAs responsibility to order medications from the backup pharmacy when needed, and document in the progress notes. -She could not find documentation Resident #1's Eliquis was ordered from the pharmacy.	C 330		

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(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
C 330	Continued From page 14 Attempted telephone interview with Resident #1's Hospice nurse on 02/17/20 at 4:20pm was unsuccessful. Interview with the Administrator on 02/17/20 at 5:10pm revealed: -He did not know Resident #1 had not received five doses of Eliquis 2.5mg. -The MAs had received training on ordering medications in between the batch fill. -He was always available to pick up medications at the pharmacy if necessary. -He did not know why the MAs had not ordered Resident #1's Eliquis when the 15 day supply was completed. Based on observation, interviews and record review, it was determined Resident #1 was not interviewable.	C 330		
C 381	10A NCAC 13G .1009(b) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that action was taken in response to the quarterly pharmaceutical review recommendation for 1 of 3 sampled residents (Resident #1). The findings are: A. Review of Resident #1's current FL2 dated	C 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060098	A. BUILDING: _____ B. WING _____	02/17/2020

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C 381	Continued From page 15 12/11/19 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), atrial fibrillation, chronic kidney disease and vascular dementia. -Physician orders included oxygen 2-4 liters via nasal canula as needed for shortness of breath (SOB). Review of Resident #1's pharmacy review dated 11/22/19 revealed the following recommendations by the consultant: -Resident #1's oxygen order for 2-4 liters to be administered as needed for shortness of breath should be clarified. -The liter flow of oxygen should be clarified by the physician. Telephone interview with the Hospice Registered Nurse (RN) on 02/17/20 revealed: -He was the RN caseworker for Resident #1. -The hospice physician had not written the original oxygen order, 2-4 liters as needed for shortness of breath. -He had not noticed Resident #1 short of breath when he assessed her during the routine visits. -The facility would have to consult with Resident #1's primary care physician for clarification of the oxygen order. Interview with the facility's RN on 02/17/20 at 2:30pm revealed: -It had not been one of her tasks to review pharmacy recommendations. -She did not know who reviewed the pharmacy recommendations. -She did not know the pharmacy had recommended clarifying Resident #1's oxygen order. -She thought Resident #1's oxygen order should be clarified and have a specific liter flow for	C 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 381	Continued From page 16 administration. -It was the responsibility of the Medication Aides to clarify orders from physicians when needed. Interview with the Administrator on 02/17/20 at 4:55pm revealed: -He did not know Resident #1's pharmacy recommendation was to clarify the oxygen order. -He expected the MAs to clarify orders with the physician if they were not specific. -The MAs should not accept an order for a medication or treatment that has a range.	C 381		