| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HAL060087 | A. BUILDING: _____ B. WING _____ | R 11/03/2020 |

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| {D 000} | Initial Comments<br><br>The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a follow-up and a complaint investigation survey onsite on 10/28/20 to 10/30/20 with a desk review survey on 11/02/20 and a telephone exit on 11/03/20. | {D 000} | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to notify a residents physician to request a refill order for an as-needed medication for 1 of 7 sampled residents (Resident #4), resulting in Resident #4 experiencing increased anxiety for at least five days.<br><br>The findings are:<br><br>Review of Resident #4's current FL-2 dated 04/10/20 revealed a diagnosis of syncope episode.<br><br>Review of Resident #4's signed physician's orders revealed a signed physician's order dated 09/11/20 for Clonazepam (a medication used to treat anxiety) 1mg by mouth twice a day as needed for anxiety.<br><br>Review of Resident #4's Progress Notes revealed:<br>-There was no documentation of staff notifying | D 273 | "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 proceedings 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." | |



Reviewed and accepted by Diana Spalding RN, BSN on 11/30/20.
DMS

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| D 273 | Continued From page 1<br><br>Resident #4's pharmacy requesting a refill for Resident #4's Clonazepam 1mg between 09/11/20 and 10/28/20.<br>-There was no documentation of staff notifying Resident #4's physician requesting a refill for Resident #4's Clonazepam 1mg between 09/11/20 and 10/28/20.<br><br>Observation of Resident #4's medications on 10/28/20 at 10:55am revealed Clonazepam was not on the medication cart.<br><br>Review of Resident #4's September 2020 Medication Administration Record (eMAR) revealed:<br>-There was an entry for Clonazepam 1mg, to be administered twice a day as needed for anxiety with no refills dated 09/11/20.<br>-Clonazepam 1mg was not documented as administered on 09/29/20, and 09/30/20.<br><br>Review of Resident #4's October 2020 eMAR revealed:<br>-There was an entry for Clonazepam 1mg, to be administered twice a day as needed for anxiety with no refills dated 09/11/20.<br>-Clonazepam 1mg was not documented as administered on 10/25/20 - 10/31/20.<br><br>Review of Resident #4's Controlled Substance Count Sheet revealed:<br>-A computer generated entry for Clonazepam 1mg by mouth twice a day as needed for anxiety.<br>-On 09/11/20, a quantity of 60 doses of Clonazepam 1mg was documented as received by facility.<br>-There were 60 out of 60 doses of Clonazepam 1mg documented as administered 09/12/20 - 10/24/20. | D 273 | D 273 10A NCAC 13F (b) Health Care<br><br>Facility RN – Wellness Director will ensure referral and follow-up to meet the routine and acute health care needs of all residents. RN will review and audit resident medications weekly to ensure the physician is notified in advance of a refill order. The order will be faxed to the pharmacy to be filled and medication placed on the cart upon receipt. Facility administrator will audit refill log weekly.<br><br>Completion Date: 11-24-2020 | |

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| D 273 | Continued From page 2<br><br>Interview with the facility's contracted pharmacist on 11/02/20 at 9:30 am revealed:<br>-Resident #4 had an order dated 09/11/20 for Clonazepam 1mg twice a day as needed for anxiety.<br>-The pharmacy dispensed a bubble pack of 60 tablets of Clonazepam 1mg on 9/11/20 to the facility with no refills.<br>-Clonazepam 1mg required a new physician's order for each refill.<br>-The facility was responsible for notifying the pharmacy when a residents as-needed medication was running out in accordance with the facility's medication administration policy.<br>-A resident being administered Clonazepam 1mg daily could experience withdrawal symptoms including increased anxiety and agitation if the medication was stopped suddenly.<br>-The pharmacy did not have any documentation of Resident #4's Clonazepam 1mg being requested for refill by facility staff or Resident #4's physician between 09/11/20 and 10/29/20.<br><br>Review of the facility's Reordering Non-Routine Medications policy revealed:<br>-All non-routine medications must be re-ordered by the Community, the pharmacy will not re-fill non-cycle medications automatically.<br>-An inventory should be taken of all non-routine medications on a weekly basis.<br>-Medications with less than a ten day supply left at the time of the inventory should be reordered.<br>-An instruction for staff to complete a pharmacy reorder form and/or by calling the pharmacy.<br><br>Interview with Resident #4 on 11/02/20 at 3:55 pm revealed:<br>-She felt anxious almost daily.<br>-She met with the physician at the facility almost weekly due to her anxiety and pain. | D 273 | | |

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| D 273 | Continued From page 3<br>-The physician had ordered Clonazepam 1mg to be administered by staff up to twice a day if she requested the medication to treat her anxiety.<br>-On 10/24/20, she requested a dose of Clonazepam 1mg in the evening and the medication aide (MA) said there were no additional doses of Clonazepam 1mg medication available to be administered and the facility was waiting on the pharmacy to send a refill of the Clonazepam 1mg medication.<br>-She requested a dose of Clonazepam 1mg and requested to know the status of the pharmacy sending a refill of the Clonazepam 1mg medication daily, between 10/25/20 and 10/29/20 and the MAs said the medication was not in the facility to be administered and they were awaiting the Clonazepam 1mg to be delivered by the pharmacy.<br>-She met with the physician at the facility on 10/30/20 and he wrote a new refill order for Clonazepam 1mg.<br>-The physician was not aware there was no Clonazepam 1mg available for administration after the last remaining dose had been administered on 10/24/20.<br>-She had tried to remain calm from the evening of 10/24/20 until she could see the physician on 10/30/20 because she knew her Clonazepam 1mg medication was not available she had been experiencing anxiousness daily between 10/25/20 and 10/29/20.<br><br>Interview with Resident #4's responsible party on 11/02/20 at 2:00pm revealed:<br>-Resident #4 suffered from generalized pain, anxiety, and other medical conditions.<br>-Resident #4 was very aware of the types of medications she was prescribed, what the medications were used for, and when she was to be administered her medications. | D 273 | | |

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| D 273 | Continued From page 4<br>-Resident #4 had been prescribed Clonazepam 1mg twice per day as needed for anxiety.<br>-On 10/29/20, Resident #4 disclosed she had been asking for her Clonazepam 1mg since on or about 10/25/20 but the facility had not received a refilled the medication from the pharmacy.<br>-On 10/29/20, she notified the physician's office after-hours staff that Resident #4 was having anxiety and the facility was unable to administer Clonazepam 1mg because the medication was not available.<br>-The facility was responsible for requesting refills of most of Resident #4's medications, including Clonazepam 1mg.<br>-She had not been notified by the facility, pharmacy or physician in October 2020 related to Resident #4's Clonazepam 1mg requiring a medication refill.<br><br>Interview with Resident #4's physician's clinical assistant on 11/02/20 at 10:21 am revealed:<br>-Resident #4's physician was responsible for prescribing Resident #4's Clonazepam 1mg twice a day as needed for anxiety.<br>-Resident #4's physician had written an order on 09/11/20 for 60 tablets of Clonazepam 1mg to be administered twice a day as needed for anxiety with no refills.<br>-Clonazepam 1mg required a new physician order each time a refill was needed.<br>-Resident #4 had been evaluated for unspecified behaviors by the physician on 10/23/20.<br>-There was no documentation of Resident #4's physician being notified between 09/11/20 and 10/30/20 by the facility requesting a refill for Resident #4's Clonazepam 1mg.<br>-There was documentation of Resident #4's responsible party notifying the physician's after-hours staff requesting a refill for Resident #4's Clonazepam 1mg. | D 273 | | |

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| D 273 | Continued From page 5<br>-Resident #4 was seen by the physician on 10/30/20 at the facility and a new refill order for Clonazepam 1mg was sent to the pharmacy on 10/30/20.<br><br>Interview with Resident #4's physician on 11/02/20 at 2:52pm revealed:<br>-Resident #4 had been prescribed Clonazepam 1mg twice a day as needed to treat anxiety.<br>-The facility was responsible for monitoring the remaining doses of Clonazepam 1mg for Resident #4 and requesting a new physicians order for Clonazepam 1mg medication refills.<br>-Resident #4 was seen at the facility on 10/23/20 and a refill order for Resident #4's Clonazepam 1mg would have been written if staff had notified her or that Resident #4's Clonazepam 1mg only had a few doses remaining.<br>-The physician was not aware the last dose of Resident #4's Clonazepam 1mg had been administered on 10/24/20 with no additional doses available to be administered until 10/30/20.<br>-The physician expected the facility to notify the physician's office at least within 3-5 days of the last dose of Clonazepam 1mg to request a refill of the medication to prevent Resident #3's anxiety from becoming worse.<br><br>Interview with a MA on 11/02/20 at 10:40 am revealed:<br>-MAs were responsible for requesting medication refills from the pharmacy through the facility's system when the MA identified 10 doses of medication remained on the medication cart.<br>-In addition to requesting medication refills through the facility's eMAR system, MAs were expected to call the pharmacy to verify receipt of the eMAR refill request.<br>-MAs were not required to document contacting the pharmacy for each refill request. | D 273 | | |

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| D 273 | Continued From page 6<br>-MAs were responsible for contacting the physician for a refill when the medication had 10 doses left.<br>-She did not notify the physician because she had not administered Clonazepam 1mg in over 2 weeks.<br>-Resident #4 had requested a dose of Clonazepam 1mg on or about 10/26/20 through 10/29/20, but the last remaining dose of Resident #4's Clonazepam 1mg was administered on 10/24/20.<br>-Resident #4 had been requesting Clonazepam 1mg twice a day as needed almost twice a day, every day during October 20.<br>-Clonazepam was considered a controlled substance medication and required a new physician's order for each refill request.<br>-She did not know if Resident #4's pharmacy had been notified of a request for refill of Clonazepam 1mg between 09/11/20 and 10/30/20.<br>-She did not know if Resident #4's physician had been notified of a request for refill of Clonazepam 1mg between 09/11/20 and 10/30/20.<br><br>Interview with the facility Administrator on 11/02/20 at 10:00 am revealed:<br>-MAs were responsible for auditing residents' medications at least weekly.<br>-MA's were responsible for requesting medication refills through the eMAR system when medications had 10 doses remaining.<br>-Resident #4's Clonazepam 1mg required a physician's order for each refill.<br>-MAs were responsible for requesting a new physician's order for Resident #4's Clonazepam 1mg by contacting the physician's office.<br>-She was not aware if MAs had requested a refill of Resident #4's Clonazepam 1mg in October 2020.<br>-She was not aware the last dose of Resident | D 273 | | |

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| D 273 | Continued From page 7<br>#4's Clonazepam 1mg had been documented as administered on 10/24/20.<br>-She was not aware Resident #4's Clonazepam 1mg was not available for administration between 10/25/20 and 10/29/20. | D 273 | | |