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
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 a follow-up survey on August 18, 2021 through August 19, 2021.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 3 of 9 exit doors were available for non-fire related egress. The findings are: Observation on 08/19/21 between 9:00am and 9:30am revealed: -Two of the three emergency exit doors on the 100 hallway had the emergency release switch covers secured shut with zip ties. -One of the emergency release switch covers had a zip tie that was hanging on the loop, but was broken.	D 067	On 8/19/21, inappropriately placed cable ties were immediately removed from the emergency release switch covers for safety. All Staff in-serviced on the fire process as well as emergency exit guidelines during staff meeting by the Executive Director. ED will monitor emergency release switch covers during daily rounds to ensure no cable ties or other unapproved restrictive devices have been applied to the covers. If this is noted, the ED will remove immediately and reeducate the team members on emergency exits.	9/7/21 10/3/21

Karen M. Polce

Received and Acknowledged 10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 067	Continued From page 1 -When the cover was lifted the alarm sounded. Observation on 08/19/21 at 9:15am of the building fire exit plan posted on the 100 hallway revealed the two hallway exit doors were included as an emergency exit. Interview on 08/19/21 at 9:45am with the local fire inspector revealed: -The emergency exit door release switch covers should not be zip tied shut. -The zip ties would require scissors, wire cutter, or a knife to remove. -It would be permissible to secure them with beaded safety ties that would break away when pulled. Interview with a staff member revealed: -They did not have the keypad code for the emergency exits on the hall ways. -"If there was an emergency they did not know how they would get the residents out of the building". -They did not know what the red emergency switch beside the exit doors was for. Interview with a second staff member revealed: -They did not know what the red emergency switch beside the exit doors was for. -They did not know how they would get the residents through the exit doors in case of an emergency. Interview with a third staff member revealed: -They did not have the code for the keypad on the exit doors. -The doors would open when the fire alarm sounded. -They had not noticed the emergency switch boxes being zip tied shut.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 067	Continued From page 2 Interview on 08/19/21 at 11:30am with the Administrator revealed: -The staff did not have the codes to the hallway exit doors because she wanted all traffic to enter and exit the building at the main entrance. -The exit doors will open in the case of a fire alarm. -She did not know that zip ties could not be used to secure the emergency door release boxes shut.	D 067		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure there were no chronic unpleasant odors in the special care unit (SCU) related to a foul smelling odor in the hallway and communal shower room in the 400 hall of the SCU. The findings are: Observation of the SCU during the initial tour on 08/18/21 at 10:05am revealed: -There was a strong odor in the 400 hall outside the men's shower room across from the medication room.	D 075	All staff in-serviced on reporting maintenance concerns, unpleasant odors throughout the community, and completing work orders during staff meeting held by Executive Director. The drain in the Memory Care dining room was capped. There is no longer an unpleasant odor present. ED will monitor for unpleasant odors during daily rounds. ED will reach out to Maintenance person for assistance if needed.	9/07/21 9/09/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 075	Continued From page 3 -The foul smell seemed to be emanating from the men's common shower. -In the shower room there were 2 drains; one on the floor of the shower stall and one on the floor of the toilet stall. -The source of the foul smell was the drain on the floor of the shower stall. Interview with a personal care aide (PCA) on 08/18/21 at 10:20am revealed: -She worked fulltime as a PCA in the SCU. -There were only 4 residents remaining in the unit. -She used the men's shower room to bathe and toilet residents. -She did not know there was a foul smell in the shower room or in the hall. -She did not know of anytime in the past that a foul smell came from the shower room. Interview with the medication aide (MA) on 08/18/21 at 08/18/21 at 10:35am revealed: -She administered medications to the residents in the assisted living (AL) and SCU halls. -She had noticed the smell in the hallway but she did not know the source. -The residents in the SCU were not bathed in the men's common shower area, but in the women's shower room past the closed double fire doors in the 400 hall that currently had no occupied rooms. -She did not provide showers to the residents in the SCU. -She thought housekeeping was addressing the foul smells in the SCU. Interview with the Maintenance Manager from the sister community on 08/18/21 at 2:27 revealed: -The smell in the SCU dining room was due to the staff not flushing the hopper.	D 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 075	Continued From page 4 -The smell was sewer gas that collected in the pipes when they became dry. -Staff needed to flush the hopper daily, and pour water into the drains at least weekly. -He had educated his staff as to this maintenance protocol, but he had not trained the staff at this facility. -He was contacted to come to this facility for specific maintenance concerns and was not the supervisor of the staff in this building. Interview with a housekeeper on 08/19/21 at 10:15am revealed: -He had never been told to perform any type of maintenance to the drains in the facility, including the SCU. -He had noticed the smell coming from the bathroom drain. -He had not been told to pour water down the drains in the bathroom. -There was a hopper that he thought had to be flushed, but he did not have a key to the room where the hopper was located. -He had never flushed the hopper. -He thought he had informed the Administrator regarding the foul smell in the SCU shower room, but was not sure. -The Administrator was his immediate supervisor since the position of Maintenance Manager was vacant. Interview with the Administrator on 08/19/21 at 12:45pm revealed: -She was aware of the foul smell emanating from the drain in the men's shower room in the SCU. -As it had been explained to her, gas builds up in the drains and creates a foul smelling odor. -The plan to eliminate the odor was to flush water through the hopper and put bleach in the drains weekly.	D 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 075	Continued From page 5 -We followed this protocol for the odor in the SCU dining room and it was effective. -She knew this weekly procedure was not effective in the men's shower floor drain so she instructed the staff to increase the flushing of the hopper and bleach in the drains to twice a week. -She had assigned the housekeeper or a designee to perform this task weekly. -She was not sure why the housekeeper would not have remembered he had performed the flushing of the hopper and adding bleach to the drains.	D 075		
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: FOLLOW-UP TO a CONTINUING A2 VIOLATION Based on these findings, the previously Unabated Type A2 Violation was abated. Non-compliance continues. Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 5 residents sampled (Resident #5) who had a physician's order for weekly weights. The findings are: Review of Resident #5's current FL2 dated 03/02/21 revealed diagnoses included Type II Diabetes, hypertension, bipolar disorder, and	D 273	RCC will verify correct weight orders on all residents, as well as ensuring all residents have a place for documentation in the weight binder. RCC or designee will review the weight binder biweekly for completion and for accuracy. This will allow for early intervention in the event that a weight is missed or a reweigh is required. Residents will be weighed per MD orders. Weights will be reviewed for completion by the RCC. The residents' weights will be reviewed in the monthly QA meeting with RCC and ED. Variances of 5% in one month or 10% in 6 months will be reported to the MD. RCC will continue to utilize the order processing system to ensure prompt, efficient and accurate processing of all new orders received.	10/4/21 10/4/21 10/4/21 10/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 6 osteoarthritis. Review of Resident #5's subsequent physician orders dated 07/21/21 revealed an order for weights to be taken weekly. Review of Resident #5's July 2021 electronic medication administration record (eMAR), from 07/21/21 through 07/31/21 revealed there was no entry for weekly weights to be taken. Review of Resident #5's electronically generated vitals report on 08/19/21 revealed: -There was an entry on 05/05/21 of a routine weight documented as 240 pounds (lbs). -The next entry was 07/21/21 of a routine weight documented as 220.6 lbs. -The next entry was 07/22/21 of a routine weight documented as 236.5 lbs. Review of the monthly weights binder located in the medication room revealed: -Resident #5 had a documented weight on 07/19/21 of 220.6. -There were no other documented weights in the binder for Resident #5. Review of Resident #5's August 2021 eMAR from 08/01/21 through 08/18/21 revealed: -There was an entry for a weight to be taken once a day on Monday. -On 08/02/21, the MA documented completion of the task with their initials. -There was no weight recorded on the eMAR. -There was no weight recorded in the electronic progress notes. -On 08/09/21, the MA documented completion of the task with their initials. -There was no weight recorded on the eMAR. -There was no weight recorded in the electronic	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 7 progress notes. -On 08/16/21, the MA documented completion of the task with their initials. -There was no weight recorded on the eMAR. -There was no weight recorded in the electronic progress notes. Interview with the MA on 08/19/21 at 11:00am revealed: -The facility policy was to take monthly weights on all the residents and record them in the weights binder in the medication room. -A physician's order was required to take weights more frequently. -She remembered the physician's order sometime in July 2021 to take Resident #5's weights weekly. -There were no parameters on the weights, or directives to send him the record of weights. -There was some question by the physician and staff as to whether the scale used for weights was accurate. -She did not know if the scale was accurate or had been calibrated. -She did not see the order for weekly weights entered on the eMAR after she took the weights on 07/21/21 and 07/22/21 so she thought it had been discontinued. -She had not taken Resident #5's weights since 07/22/21. Attempted telephone interview with a another MA on 08/19/21 at 12:01 was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 08/19/21 at 12:35pm revealed: -Medication orders should be processed by the MA who received the order. -She also processed orders if the MAs were busy. -The order should go to the pharmacy and would	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 8 be entered on the eMAR by their staff. -She would approve new orders once the pharmacy entered the order. -The eMAR entry for weights should have a drop down menu to document the weights recorded. -The MAs could also enter the weights in the weight binder kept in the medication office. -The first time she saw the order for Resident #5's weekly weights was 08/01/21. -She was not sure if it had been overlooked in her mail box or if it had been filed in the resident's chart. -The order was entered on the eMAR by the pharmacy staff on 08/02/21 and she approved it. -She did not notice there was no drop down box for the MAs to document the weights. -The MAs did not report to her they were not recording Resident #5's weights. -She did not know why the physician had ordered weekly weights or when he wanted that information to be sent to him. Interview with the Administrator on 08/19/21 at 12:55pm revealed: -It was the responsibility of the MAs and the RCC to process new orders. -The orders should be sent to the pharmacy and their staff enter the orders on the eMARs. -The RCC approves the orders when they have been entered and at that point the order becomes active on the eMARS for the MAs to administer. -It was the responsibility of the RCC to review all incoming orders and ensure they are processed correctly. -She did not know Resident #5 had an order for weekly weights on 07/21/21 and those weights were not recorded on 08/02, 08/09/21 or 08/16/21. Attempted telephone interview with Resident #	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 9 primary care physician (PCP) on 08/19/21 at 10:40am was unsuccessful.	D 273		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the prescribed or scheduled times for 1 of 6 sampled residents (Resident #2) resulting in scheduled insulin with multiple administration times being administered too close to the next scheduled administration times or administered too early or too late. The findings are: Review of the facility's Medication Management Clinical Standard Operating Procedure dated 07/20 revealed: -Medications must be administered within a two-hour time frame defined as; one hour before and one hour after the scheduled medication time as per state rules and regulations. -Medication shall not be administered two hours before or two hours after the scheduled time. -All medications shall be reviewed that are	D 364	The Med Techs were re-educated on required medication administration guidelines including timeframe of one hour before or one hour after the prescribed or scheduled time. Education provided by Executive Director. The RCC will evaluate med pass times in addition to speaking with the Med Techs to ensure the med pass times are reasonable for compliance with med pass completion and will make adjustments if needed. The RCC will run the EMAR compliance report daily to monitor for late medications as well as any other compliance concerns. Report will be reviewed with ED in management meeting daily. PCP notification will occur as appropriate by RCC or designee.	9/7/21 10/4/21 10/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 364	Continued From page 10 ordered for specific times to ensure actual administration times are compliant with physician orders. Review of Resident #2's current FL-2 dated 04/12/21 revealed diagnoses included bipolar disorder, depression, arthritis, and diabetes. Review of Resident #2's current FL-2 dated 04/12/21 revealed: -In the medications section, there was a note documenting to see physician's orders. -There were physician's orders attached to the FL2 and dated 04/12/21 which included orders for Humalog 100 unit/ml (a rapid-acting insulin used to lower elevated blood sugar levels) administer per sliding scale before meals. Review of Resident #2's July 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Humalog 100 unit/ml administer per sliding scale three times daily before meals and scheduled for administration at 7:30am, 11:30am, and 4:30pm. -Humalog was documented as administered late for 6 of 12 opportunities from 07/24/21 through 07/28/21. -On 07/24/21, Humalog was scheduled for administration at 7:30am, but was documented as administered late at 10:14am; the next dose was scheduled for administration at 11:30am but was documented as administered at 12:42pm. -On 07/25/21, Humalog was scheduled for administration at 7:30am but was documented as administered late at 8:43am; the next dose was scheduled for administration at 11:30am was documented as administered at 2:31pm. -On 07/28/21, Humalog was scheduled for administration at 11:30am and 4:30pm but was	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 364	Continued From page 11 documented as administered late at 8:02pm. Review of Resident #2's August 2021 eMAR revealed: -There was an entry for Humalog 100 unit/ml administer per sliding scale three times daily before meals and scheduled for administration at 7:30am, 11:30am, and 4:30pm. -Humalog was documented as administered late for 10 of 42 opportunities from 08/03/21 through 08/17/21. -On 08/03/21, Humalog was scheduled for administration at 11:30am, but was documented as administered late at 3:09pm; the next dose was scheduled for administration at 4:30pm but was documented as administered at 5:51pm. -On 08/05/21, Humalog was scheduled for administration at 4:30pm but was documented as administered late at 5:59pm. -On 08/07/21, Humalog was scheduled for administration at 7:30am but was documented as administered late at 9:10am; the next dose was administered at 11:30am. -On 08/10/21, Humalog was scheduled for administration at 4:30pm but was documented as administered late at 5:55pm. -On 08/11/21, Humalog was scheduled for administration at 4:30pm but was documented as administered late at 6:21pm. -On 08/12/21, Humalog was scheduled for administration at 4:30pm but was documented as administered late at 5:59pm. -On 08/14/21, Humalog was scheduled for administration at 4:30pm but was documented as administered late at 5:46pm. -On 08/15/21, Humalog was scheduled for administration at 4:30pm but was documented as administered late at 5:41pm. -On 08/17/21, Humalog was scheduled for administration at 7:30am but was documented as	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 364	Continued From page 12 administered late at 9:01am; the next dose was administered at 11:33am. Interview with Resident #2 on 08/19/21 at 8:15am revealed: -He did not always get his insulin administered before his meals. -Some days his insulin was administered after he ate his supper. -Some days he was told to wait to eat by the medication aide (MA) because his insulin was going to be administered first. -He did not know the exact days his insulin was administered late but most of the time it was in the evening before supper. -He was concerned about his blood sugar getting too low because before he moved into the facility, he had episodes of passing out because his blood sugar was too low if he did not eat. Interview with the first shift MA on 08/19/21 at 8:45am revealed: -When she administered Resident #2's insulin she made sure to go to him during the medication pass to allow time to check his blood sugar and administer his insulin before he ate his breakfast and lunch. -It was a challenge at times because she was the only MA on her shift. -Sometimes she ran behind time at 7:30am and there was not another MA to help. Telephone interview with the second shift MA on 08/19/21 at 1:00pm revealed: -She tried to administer Resident #2's insulin on time. -There were times the computer did not remain connect to the internet, so she waited for the computer to come back online or connect to Resident #2's eMAR with her cellphone.	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 364	Continued From page 13 -There were times she had to go to the dining room and get Resident #2 to come back out of the dining room to get his insulin administered where the computer connected to the internet. -She told the RCC and the Administrator about the computer issues. Interview with the Resident Care Coordinator (RCC) on 08/19/21 at 9:45am revealed: -She knew Resident #2's insulin was late because MAs did not show up for their shift, so she had to administer Resident #2's insulin. -There were issues with the computer connecting to the internet in certain areas of the building, but the MAs could use their cellphone to connect to the eMAR and document Resident #2's insulin. -She ran a daily facility Medication Compliance report for the previous day and reviewed Resident #2's insulin administration times. -She did not review Resident #2's monthly eMAR that captured late medication administration times. Interview with the Administrator on 08/19/21 at 11:00am revealed: -She did not know Resident #2's insulin was administered late. -She expected the MAs to administer Resident #2's insulin before his meals as ordered and document it on time. -The MAs reported problems with the connection to the wireless router when documenting the residents' medication and she put in a work order to get it repaired. -The MAs were capable of pulling up Resident #2's eMAR on their cellphone and document medication administration with cell data. -When she reviewed the facility's Medication Compliance report with the RCC it did not show Resident #2's insulin late administration times.	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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 364	Continued From page 14 -The facility's Medication Compliance report was printed daily to capture the previous day's medication administration times. -She did not know how to run an eMAR that included all of the dates and times of Resident #2's insulin late administration times until today (08/19/21).	D 364		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes	D935	The BOC will complete a 100% Med Tech employee file audit to ensure that all active employees have completed the required medication aide trainings and competency skills check offs. The BOC will ensure that the required 5/10 or 15 Hour Training Program Certificate of Completion is in the Med Tech's file, reflecting successful completion of the NC State required Med Tech training program. The ED will sign off on all new hires once all required paperwork is received indicating a complete employee file. The BOC will continue to use and review the established tickler system to note the dates of completion of required trainings of the Med Tech as well as upcoming due date of required trainings.	10/4/21 10/4/21 10/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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
D935	Continued From page 15 training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (B & C) who administered medications had completed the 5, 10, or 15-hour medication administration training course. The findings are: 1. Review of Staff B's, medication aide's (MA) personnel record revealed: -Staff B was hired on 02/23/17. -There was documentation Staff B passed the written MA exam on 04/04/03. -There was documentation of a Medication Clinical Skills Competency Validation dated 03/10/17. -There was no documentation Staff B completed the 5, 10, or 15-hour medication administration training course. -Section 3 of the Facility Medication Aide Verification form was not completed. -There was no verification of employment prior to 2016. Review of a resident's July and August 2021 electronic medication administration record	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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
D935	Continued From page 16 (eMAR) revealed Staff B documented the administration of medications 17 days in July 2021 and 8 days in August 2021. Telephone interview with Staff B on 06/02/21 at 3:50pm revealed: -She had worked at the facility since 2017 as a MA on second and third shift. -She administered medications independently. -She had not received the 5, 10, or 15-hour medication aide training. -She did not know she needed to complete the 5, 10, or 15-hours of medication aide training. -She was told her corporate computer medication training hours were acceptable in place of the 5, 10, or 15-hours of medication aide training. Refer to interview with the Administrator on 08/19/21 at 11:00am. 2. Review of Staff C's, medication aide's (MA) personnel record revealed: -Staff C was hired on 12/30/19. -There was documentation Staff C passed the written MA exam on 09/29/20. -There was documentation of a Medication Clinical Skills Competency Validation dated 12/02/20. -There was documentation Staff C completed the 5-hour medication administration training course on 09/21/20 and signed by the trainer on 09/28/21. -There was documentation Staff C completed the 10-hour medication administration training course on 10/02/20 but the document was not signed by the trainer. Review of a resident's July and August 2021 electronic medication administration record (eMAR) revealed Staff C documented the	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092203	A. BUILDING: _____ B. WING _____	R 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM COMMONS	809 WEST CHATHAM STREET CARY, NC 27512

(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
D935	Continued From page 17 administration of medications 5 days in July 2021 and 2 days in August 2021. Interview with Staff C on 08/19/21 at 11:45am revealed: -She had worked at the facility since 2019 as the Administrator. -She administered medications independently when staff was not available. -She thought she received the 5, 10, or 15-hour medication aide training in October 2019. -She did not know her certificate of completion was not signed by the trainer. -She was told her corporate computer medication training hours were acceptable in place of the 5, 10, or 15-hours of medication aide training. Refer to interview with the Administrator on 08/19/21 at 11:00am. Interview with the Administrator on 08/19/21 at 11:00am revealed: -She and the BOM were responsible for ensuring all personnel records were complete. -The BOM was quarantined at home. -She had access to all the personnel records. -She and the BOM audited all the personnel records since June 2021. -They did not look for the MA's completion of the 5, 10, or 15-hour medication aide training. -They accepted and counted the MA's annual corporate computer training hours on medications as hours completed in place of the 5, 10, or 15-hour medication aide training. -Somebody although she could not recall who told her the corporate computer medication training hours were acceptable in place of the 5, 10, or 15-hour medication aide training.	D935		