STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTHBERTSON VILLAGE AT ALDERSGATE	3800 SHAMROCK DRIVE CHARLOTTE, NC 28215

(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 an annual survey on April 12, 2022 to April 13, 2022.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff C's personnel record revealed: - Staff C was hired on 03/01/22 by the facility's home health (HH) agency as a sitter. - There was no documentation of a Healthcare Registry check (HCPR) being conducted prior to Staff C working in the facility. Interview with Resident Care Director (RCD) on 04/13/22 at 2:15pm revealed: -The facility did not maintain an employee file for HH department staff on site at the facility. -She had requested on the HH agency send over Resident C's employee record for review on 04/13/22.	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

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D 137	Continued From page 1 - She was not aware there was no HCPR check documentation in Resident C's employee file. - She was not sure if the HH agency checked the HCPR status for their staff. - She had reached out to the HH agency to see if there was any additional paperwork for Staff C that they could send over today (04/13/22). -No additional information was sent. Interview with Administrator on 04/13/22 at 4:30pm revealed: - Staff C worked for the facility's HH agency and worked as a sitter for a resident who needed additional supervision. - Today was Staff C's first day working as a sitter for the resident. - The HH agency was responsible for completing all qualification and documentation for new hires in their department. - She was not aware that a HCPR check would need to be conducted for staff working in the facility through the HH agency. - She checked with the HH agency today (04/13/22) and they were not aware that a HCPR check needed to be completed prior to staff working in the facility as sitters. Attempted interview with Staff C on 04/13/22 at 4:08pm was unsuccessful.	D 137		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

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D 161	Continued From page 2	D 161		

licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.

This Rule is not met as evidenced by:
Based on observations, record review and staff interview, the facility failed to ensure one of three staff (Staff C) was competency validated by return demonstration for any personal care tasks necessary for the performance of her individual job assignments.

The findings are:

Observation of Resident #5 on 04/13/22 at 10:20am revealed:
-Resident #5 was sitting in his wheelchair in the community room with an agency personal care aide (PCA) sitting in a chair next to him.
-The PCA transported the resident back to his bedroom to check his catheter leg bag and struggled to transfer the resident from the wheelchair to the bed.
-When questioned, she did not know if the resident was a 2 person assist.
-The wheelchair had several pieces of food on the seat.
-When lying on the bed, the catheter bag was exposed and down near his ankle, approximately half full with amber colored urine.
-The strap used to secure the leg bag was twisted and dangling around the ankle.
-The PCA did not know how to secure the bag properly.
-She stated it was her first day and all she was told to do was to check the bag every 2 hours and

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D 161	Continued From page 3	D 161		

empty as needed.
-When she removed the resident's brief there was a quarter size bowel movement caked in between his buttocks, and the surrounding area reddened.
-The PCA did not know where any cleaning supplies were or where to find new briefs.
-The lead medication aide (MA) was called in and stated resident's were cleaned with face cloths and she would have to procure some for the resident from the laundry room.
-She also looked for soap in the bathroom and could not find any at that time.
-The resident stated the catheter tubing "hurt" at the insertion site.
-The site was not irritated or reddened and there was no discharge.

Interview with the agency personal care aide (PCA) on 04/13/22 at 10:40am revealed:
-She was a certified nurses assistant (CNA) and this was her first day as a caregiver with Resident #5.
-She had not seen a careplan for the resident and her only duties were to sit with him so he did not fall and assist him with activities of daily living.
-She could ask the MA if she had any questions regarding the resident's care.
-She did not know where the supplies for personal care were located and did not know facecloths were used to clean the resident when changing a brief.
-She did not know he was a 2 person assist with transfers.

Interview with the lead MA on 04/13/22 at 10:48am revealed:
-The MAs provided the catheter care for Resident #5.
-She applied a prescribed cream to the insertion

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	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

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CUTHBERTSON VILLAGE AT ALDERSGATE	3800 SHAMROCK DRIVE CHARLOTTE, NC 28215

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D 161	Continued From page 4	D 161		

site on the lower abdomen and covered the site with a 4x4 dressing daily.
-She also cleaned the tubing from the insertion site to the bag with soap and water.
-The band that secured the catheter bag to the upper thigh was faulty and she would have to order a new one.
-The band had lost its elasticity and was not able to secure the catheter bag to the upper leg.
-She did not know why there were no face cloths and soap in the bathroom.
-The PCA's should be ensuring the resident's have soap and face cloths in their bathroom for use.

Interview with a second PCA on 04/13/22 at 1:55pm revealed:
-She received her training and orientation from the facility's HH RN.
-Her duties included: grooming, bathing, showering, incontinence care, feeding assistance, toileting and taking him to activities.
-It took two staff members to give care to Resident #5 because he was combative at times.
-Instruction for Resident #5's care came from the facility's HH department.

Review of Staff C's home health (HH) agency personnel record revealed:
- Staff C was hired on 03/01/22 by the facility's HH agency as a sitter and personal care aide (PCA).
- Staff C had a skills assessment completed by the HH agency upon hire but the assessment did not include all tasks included on the licensed healthcare professional support (LHPS) validation documentation.
- There was no documentation that a LHPS task validation had been completed for Staff C in the facility.

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	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTHBERTSON VILLAGE AT ALDERSGATE	3800 SHAMROCK DRIVE CHARLOTTE, NC 28215

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D 161	Continued From page 5 Interview with Resident Care Director (RCD) on 04/13/22 at 2:15pm revealed: -The facility did not maintain an employee file for HH agency staff on site at the facility. -She had requested the HH agency send over Resident C's employee record for review. -She was not aware there was no comprehensive LHPS check documentation in Resident C's employee file. -She was not sure if the HH agency checked off their staff for LHPS. -She had reached out to the HH agency to see if there was any additional paperwork for Staff C that they could send over today (04/13/22). -No additional information was sent. Interview with Administrator on 04/13/22 at 4:30pm revealed: -She was aware the HH agency Registered Nurse (RN) completed a skills assessment prior to the staff member working in the facility. -She was not aware the skills assessment completed by the HH agency was different from the LHPS validation and that it was not as comprehensive as the LHPS validation. -She relied on the HH agency to provide all the training necessary for their staff to be in compliance with the regulations. Attempted interview with Staff C on 04/13/22 at 4:08pm was unsuccessful.	D 161		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTHBERTSON VILLAGE AT ALDERSGATE	3800 SHAMROCK DRIVE CHARLOTTE, NC 28215

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D 269	Continued From page 6 care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide personal care assistance for 1 of 5 sampled residents (#5) related to incontinence care. Review of Resident #5's current FL2 dated 05/25/21 revealed: -Diagnoses included dementia with behaviors, Parkinson's Disease and a left femur fracture. -He was constantly disoriented and semi-ambulatory with the use of a wheelchair. -The recommended level of care was the Special Care Unit (SCU). Review of Resident #5's Care Plan dated 07/02/21 revealed: -It was signed by a provider. -He was totally dependent on staff for bathing. -He required extensive assistance with toileting and dressing. Review of Resident #5's Care Plan dated 04/01/22 revealed: -The care plan was created by staff from the facility's HH agency. -Active goals included catheter care, clean clothing on each shift and extensive assistance with bathing, hygiene and toileting. -Catheter care included cleaning the catheter tubing with soap and water and wearing a band around his abdomen to keep the catheter secure. -There were instructions to ask the SCU staff to	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTHBERTSON VILLAGE AT ALDERSGATE	3800 SHAMROCK DRIVE CHARLOTTE, NC 28215

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D 269	Continued From page 7	D 269		

assist with activities of daily living (ADL) such as hygiene, toileting and dressing.
-The Care Plan was not signed by the Primary Care Provider (PCP).

Review of Resident #5's SCU quarterly profile dated 03/16/22 revealed:
-He was dependent on staff to meet all his dressing and hygiene needs as well as showering/bathing due to unable to participate.
-He required a staff managed bowel and bladder program.

Observation of Resident #5 on 04/13/22 at 10:20am revealed:
-Resident #5 was sitting in his wheelchair in the community room with a personal care aide (PCA) sitting in a chair next to him.
-The PCA transported the resident back to his bedroom to check his catheter leg bag and struggled to transfer the resident from the wheelchair to the bed.
-When questioned, she did not know if the resident was a 2 person assist.
-The wheelchair had several pieces of food on the seat.
-When lying on the bed, the catheter bag was exposed and down near his ankle, approximately half full with amber colored urine.
-The strap used to secure the leg bag was twisted and dangling around the ankle.
-The PCA did not know how to secure the bag properly.
-The PCA stated it was her first day and all she was told to do was to check the bag every 2 hours and empty as needed.
-When the PCA removed the resident's brief his buttocks were red and a dried bowel movement remained.
-The PCA did not know where personal care

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	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTHBERTSON VILLAGE AT ALDERSGATE	3800 SHAMROCK DRIVE CHARLOTTE, NC 28215

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D 269	Continued From page 8 products or clean briefs were located. Interview with the agency caregiver and personal care aide (PCA) on 04/13/22 at 10:40am revealed: -She had not seen a careplan for Resident #5. -Her duties were to sit with him so he did not fall and assist him with activities of daily living. -She could ask the MA if she had any questions regarding the resident's care. -She did not know where the supplies were located and did not know facecloths were used to clean the resident. -She did not know Resident #2 was a 2 person assist with transfers. Interview with the lead MA on 04/13/22 at 10:48am revealed: -The MAs provided the catheter care for Resident #5. -She applied a prescribed cream to the insertion site on the lower abdomen and covered the site with a 4x4 dressing daily. -She also cleaned the tubing from the insertion site to the bag with soap and water. -The band that secured the catheter bag to the upper thigh was faulty and she would have to order a new one. -The band had lost its elasticity and was not able to secure the catheter bag to the upper leg. -She did not know why there were no face cloths and soap in the bathroom. -Resident's were cleaned with face cloths and she would have to procure some for the resident from the laundry room. -She also looked for soap in the bathroom and could not find any at that time. -The PCA's should be ensuring the resident's have soap and face cloths in their bathroom for use.	D 269		

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	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTHBERTSON VILLAGE AT ALDERSGATE	3800 SHAMROCK DRIVE CHARLOTTE, NC 28215

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D 269	Continued From page 9 -Resident #5 was toileted every 2 hours by staff and his catheter bag was emptied every shift or as needed. -He was a 2 person assist during transfers and with showers. Interview with a second PCA on 04/13/22 at 1:55pm revealed: -She was assigned as a sitter for Resident #5. -She received her training and orientation from the facility's HH RN. -Her duties included: grooming, bathing, showering, incontinence care, feeding assistance, toileting and taking him to activities. -It took two staff members to give care to Resident #5 because he was combative at times. -Instruction for Resident #5's care came from the facility's HH agency. Interview with the Resident Care Coordinator (RCC) RN on 04/13/22 at 11:50am revealed: -Resident #5's family member hired the facility's HH sitter to help care for him. -The sitters were given a care plan and were expected to provide care according to the care plan. -The facility's HH staff were responsible for training, orienting and providing the care plan to their staff. -She did not manage the facility's HH staff. Interview with the Administrator on 04/13/22 at 4:56pm revealed: -The facility's HH staff staff completed their own care plans on the resident and the RCC RN verified the information was correct. -The facility's HH staff were expected to reference the care plan through their company's application on their phones to provide services for the resident.	D 269		

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	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTHBERTSON VILLAGE AT ALDERSGATE	3800 SHAMROCK DRIVE CHARLOTTE, NC 28215

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D 269	Continued From page 10 -If the HH staff needed help, the staff from the SCU were expected to assist them. -If the HH did not meet the resident's personal care needs then the facility staff were responsible for ensuring that the personal care needs were met. Attempted telephone interview with the facility's HH Director on 04/13/22 at 1:08pm was unsuccessful. Based on interviews, observations and record reviews, it was determined Resident #5 was not interviewable.	D 269		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to administer medications as ordered by the primary care provider (PCP) for 1 of 5 sampled residents (Resident #4). The findings are: Review of Resident #4's current FL2 dated 11/24/21 revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTHBERTSON VILLAGE AT ALDERSGATE	3800 SHAMROCK DRIVE CHARLOTTE, NC 28215

(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 358	Continued From page 11	D 358		

-Diagnoses included vascular dementia, tibia fracture, femur fracture and repeated falls.
-There was an order for Coumadin 3mg, used to treat or prevent blood clots, take one tablet at bedtime.

Review of Resident #4's physician's orders dated 01/18/22 revealed:
-There was an order for Coumadin 2.5mg tablet every evening on Tuesday, Thursday, Friday and Sunday at 6:00pm.
-There was an order for Coumadin 3mg tablet every evening on Monday, Wednesday and Saturday at 6:00pm.

Review of Resident #4's January 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Coumadin 2.5mg tablet every evening on Tuesday, Thursday, Friday and Sunday at 6:00pm.
-There was no documentation on 01/30/22 that Coumadin 2.5mg was administered.
-There was an entry for Coumadin 3mg tablet every evening on Monday, Wednesday and Saturday at 6:00pm.
-There was documentation Coumadin 3.0mg was administered on Friday (01/28/22) instead of Coumadin 2.5mg.

Review of Resident #4's physician's orders dated 02/01/22 revealed:
-There was an order for Coumadin 2.5mg tablet every evening on Tuesday, Thursday, and Sunday.
-There was an order for Coumadin 3mg tablet every evening on Monday, Wednesday, Friday and Saturday.

Review of Resident #4's February 2022 eMAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUTHBERTSON VILLAGE AT ALDERSGATE	3800 SHAMROCK DRIVE CHARLOTTE, NC 28215

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D 358	Continued From page 12	D 358		

revealed:
-There was an entry for Coumadin 2.5mg tablet every evening on Tuesday, Thursday, and Sunday at 6:00pm.
-There was no documentation Coumadin 2.5mg was administered on Thursday (02/04/22).
-There was an entry for Coumadin 3mg tablet every evening on Monday, Wednesday, Friday and Saturday at 6:00pm.
-There was no documentation Coumadin 3.0mg was administered on Friday (02/05/22).

Telephone interview with Resident #4's PCP on 04/13/22 at 1:25pm revealed:
-She was not aware the resident's Coumadin was not administered as ordered.
-If she had been aware, she would have probably ordered an additional lab to be drawn because the Coumadin was not administered as ordered in February 2022, expressed as an international normalized ratio (INR) (used to monitor how well the blood thinning medication was working to prevent blood clots).

Interview with the Resident Care Coordinator (RCC) on 04/13/22 at 4:40pm revealed:
-It was the responsibility of the RCC or designee to check the physician orders with the orders transcribed on the eMAR.
-If there was a medication error identified a medication report would be completed and submitted to the facility's Medical Director, the RCC and the pharmacy consultant, and the resident's PCP would be notified.
-The RCC also ran a missed medication report weekly.
-She would identify why the medication was missed, fill out a medication error report, and put measures in place to prevent the error from happening again.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 13 -This may include MA training or increased oversight of the missed medication report. -She did not know Resident #4's Coumadin was missed on 02/04/22 and 02/05/22, and given in error on 01/28/22 and 01/30/22. -A medication error report was not completed on these dates and the PCP not notified since she was not aware of the error. Interview with the Administrator on 04/13/22 at 4:40pm revealed: -She was not made aware of the Coumadin errors on 01/28/22, 01/30/22, 02/04/22 and 02/05/22. -It was the responsibility of the MAs to inform the RCC if a medication was not administered as ordered. -It was the RCC's responsibility to review the eMARs and follow up on any missed medications.	D 358		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060059	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 464	Continued From page 14	D 464		

specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents, (Residents #4), residing in the Special Care Unit (SCU) had a care plan completed within 30 days of admission to the SCU and signed by a physician.

The findings are:

Review of the facility's current license effective revealed the facility was licensed with a special care unit (SCU) with a capacity of 61 beds.

1. Review of Resident #4's current FL2 dated 11/24/21 revealed:
-Diagnoses included dementia, Atrial fibrillation, repeated falls, muscle weakness and vitamin D deficiency.
-The recommended level of care was the special care unit (SCU).

Review of Resident #4's Resident Register revealed he was admitted to the SCU on 07/09/21.

Review of Resident #4's record revealed there was no documented SCU Resident Profile and Care Plan completed within 30 days of admission.

Telephone interview with Resident #4's primary care provider (PCP) on 04/13/22 at 1:25pm revealed she could not remember if she was sent

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D 464	Continued From page 15	D 464		

a care plan for Resident #4 within 30 days of his admission.

Interview with the Resident Care Coordinator (RCC) on 04/13/22 at 4:40pm revealed:
-The Tier level assessment was used by the facility to determine the level of care requiring assistance by the staff.
-It would be completed by the facility's social worker, and each assessment category would be rated on a point system.
-The points would determine the level of care and the corresponding financial commitment.
.The Tier level assessment would be used by the nurse to develop a Care Plan.
-The resident's Care Plan would be sent to the PCP for his review and signature.
-There was no documentation of a care plan completed for Resident #4 thirty days after admission to the facility, and to the present.
-There were Tier Assessments completed on 11/10/21 and 01/18/22.
-She was not aware Resident #4's Care Plan completed within 30 days after admission was not able to be located.
-She thought she had completed the Care Plan within that timeframe.

Interview with the Administrator on 04/13/22 at 4:40pm revealed:
-It was the responsibility of the RCC to complete a care plan for the residents within 30 days of admission.
-She did not know why that was not in his record.
-A Tier Assessment was not a care plan.
-Her expectation was that a care plan would be completed within 30 days of admission ans sent to the PCP for his review and signature.

Based on observations, interviews and record

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D 464	Continued From page 16 review Resident #4 was not interviewable. There was no Care Plan produced by the facility staff for Resident #4 before survey exit on 04/13/22 at 5:30pm.	D 464		