

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 06/02/2022
NAME OF PROVIDER OR SUPPLIER CARMEL HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 CARMEL ROAD CHARLOTTE, NC 28226		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 06/01/22 to 06/02/22.	D 000			
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult 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 medication orders for 1 of 5 sampled residents (#4) who was prescribed a supplement to assist in digestion. The findings are: Review of Resident #4's current FL2 dated 01/20/22 revealed: -Diagnoses included dementia, hypertension, and hypothyroidism. -There was an order for aloe vera juice (contains enzymes that help break down sugars and fats which helps to keep the digestive tract running smoothly) to be given once a day in 8 oz. of liquid	D 344			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 344	Continued From page 1 at 12:00pm. Observation of Resident #4's aloe vera juice container label on 06/01/22 at 12:14pm revealed the recommended serving was 4 to 8 oz. at meal-time. Observation of the medication pass for Resident #4 on 06/01/22 at 12:16pm, the noon medication aide (MA) administered an 8 oz. cup of aloe vera juice to Resident #4. Interview with the medication aide (MA) administering Resident #4's medications on 06/01/22 at 12:15pm revealed: -Resident #4's order for the aloe vera did not specify an amount to be administered. -Resident #4 always drank the aloe vera juice without it being mixed in another type of juice. Interview with the same MA on 06/02/22 at 1:40pm revealed: -She followed the recommended serving amount on the aloe vera juice label when administering it to Resident #4. -She would ask Resident #4 if she wanted a 4 oz. serving or an 8 oz. serving each day before she prepared the aloe vera juice for administration. -The Executive Director of Nursing (DON) was responsible for double checking new orders entered into the eMAR by the pharmacy. -The DON or MAs were responsible to call and clarify orders that were not clear. Review of Resident #4's April 2022 electronic Medication Administration Records (eMAR) revealed: -There was an entry for aloe vera juice once a day in 8 oz. of liquids scheduled at 12:00pm. -The aloe vera juice was documented as	D 344		

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D 344	Continued From page 2 administered daily at 12:00pm from 04/01/22 to 04/30/22. -On 04/03/22, the aloe vera juice was not administered due to resident refusal. Review of Resident #4's May 2022 eMAR revealed: -There was an entry for aloe vera juice once a day in 8 oz. of liquids scheduled at 12:00pm. -The aloe vera juice was documented as administered daily at 12:00pm from 05/01/22 to 05/31/22. Review of Resident #4's June 2022 eMAR revealed: -There was an entry for aloe vera juice once a day in 8 oz. of liquids scheduled at 12:00pm. -The aloe vera juice was documented as administered at 12:00pm on 06/01/22. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/01/22 at 2:57pm revealed: -The pharmacy did not provide the aloe vera juice for Resident #4. -The pharmacy had been responsible for entering the primary care provider's (PCP) order for the aloe vera onto Resident #4's eMAR. -He expected the MAs to follow the recommended serving amounts found on the aloe vera juice label. Telephone interview with the Administrator on 06/02/22 at 3:06pm revealed: -It was the Director of Nursing's (DON) responsibility or the MAs to call the PCP and clarify any medication order that was not clear. -The DON or the MAs should have called and clarified the amount of aloe vera juice to administer to Resident #4 as soon as they	D 344		

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D 344	Continued From page 3 realized the order did not specify the amount to be administered. Attempted interview with Resident #4's PCP on 06/02/22 at 11:06am was unsuccessful. Based on observations, interviews, and record review it was determined Resident #4 was not interviewable.	D 344		
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 reviews, the facility failed to administer medications as ordered for 2 of 13 sampled residents (#4 and #5) observed during medication pass including errors with an antioxidant supplement (#4) and a medication to treat a thyroid disorder (#5). The findings are: The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 12:00pm medication pass on 06/01/22 and 7:00am and 8:00am medication pass on 06/02/22.	D 358		

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D 358	Continued From page 4 1. Review of Resident #4's current FL2 dated 01/20/22 revealed: -Diagnoses included dementia, hypertension, and hypothyroidism. -There was an order for aloe vera juice (contains enzymes that help break down sugars and fats which helps to keep the digestive tract running smoothly) to be given once a day in 8 oz. of liquid at 12:00pm. Observation of Resident #4's aloe vera juice container label on 06/01/22 at 12:14pm revealed the recommended serving was 4 to 8 oz. at meal-time. Observation of the medication pass for Resident #4 on 06/01/22 at 12:16pm, the noon medication aide (MA) administered an 8 oz. cup of aloe vera juice to Resident #4. Interview with the medication aide (MA) administering Resident #4's medications on 06/01/22 at 12:15pm revealed: -Resident #4's order for the aloe vera did not specify an amount to be administered. -Resident #4 always drank the aloe vera juice without it being mixed in another type of juice. Interview with the same MA on 06/02/22 at 1:40pm revealed: -She followed the recommended serving amount on the aloe vera juice label when administering it to Resident #4. -She would ask Resident #4 if she wanted a 4 oz. serving or an 8 oz. serving each day before she prepared the aloe vera juice for administration. -Resident #4 had not complained of any gastric or intestinal upset after receiving the aloe vera juice daily in 4 oz. or 8 oz. quantities.	D 358		

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D 358	Continued From page 5 Review of Resident #4's April 2022 electronic Medication Administration Records (eMAR) revealed: -There was an entry for aloe vera juice once a day in 8 oz. of liquids scheduled at 12:00pm. -The aloe vera juice was documented as administered daily at 12:00pm from 04/01/22 to 04/30/22. -On 04/03/22, the aloe vera juice was not administered due to resident refusal. Review of Resident #4's May 2022 eMAR revealed: -There was an entry for aloe vera juice once a day in 8 oz. of liquids scheduled at 12:00pm. -The aloe vera juice was documented as administered daily at 12:00pm from 05/01/22 to 05/31/22. Review of Resident #4's June 2022 eMAR revealed: -There was an entry for aloe vera juice once a day in 8 oz. of liquids scheduled at 12:00pm. -The aloe vera juice was documented as administered at 12:00pm on 06/01/22. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/01/22 at 2:57pm revealed: -The pharmacy did not provide the aloe vera juice for Resident #4. -The pharmacy had been responsible for entering the primary care provider's (PCP) order for the aloe vera onto Resident #4's eMAR. -He expected the MAs to follow the recommended serving amounts found on the aloe vera juice label. Telephone interview with a pharmacist from the	D 358			

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D 358	Continued From page 6 facility's contracted pharmacy on 06/02/22 at 11:23am revealed: -He had researched the possible side effects of taking too much aloe vera juice. -He had not found any adverse effects from drinking too much of it. Telephone interview with the local poison control center on 06/02/22 at 11:29am revealed: -When taken in larger than recommended quantities, aloe vera juice could cause stomach upset and have laxative effects. -Aloe vera taken in amounts of 1 gm per day could cause lethal effects due-to-the effects of dehydration. -The aloe vera juice which was being used by Resident #4 was classified as a "minimally" toxic substance. -Symptoms of diarrhea would dictate whether the resident should drink more or less of the aloe vera juice. Telephone interview with the Administrator on 06/02/22 at 3:06pm revealed: -It was the Director of Nursing's (DON) responsibility or the MAs to call the PCP and clarify any medication order that was not clear. -The DON or the MAs should have called and clarified the amount of aloe vera juice to administer to Resident #4 as soon as they realized the order did not specify the amount to be administered. Attempted interview with Resident #4's PCP on 06/02/22 at 11:06am was unsuccessful. Based on observations, interviews, and record review it was determined Resident #4 was not interviewable.	D 358		

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D 358	Continued From page 7 2. Review of Resident #5's current FL2 dated 02/03/22 revealed: -Diagnoses included Hashimoto's thyroiditis (when the immune system attacks the thyroid gland causing inflammation and eventual decrease in thyroid hormone production), vertigo, and insomnia. -There was an order for levothyroxine (used to treat Hashimoto's thyroiditis) 25mcg 1 tablet daily. Review of Resident #5's order dated 02/04/22 revealed: -Discontinue levothyroxine 25mcg. -Start levothyroxine 50mcg 1 tablet every morning at least 30 minutes before food or other medications. Review of Resident #5's thyroid stimulating hormone test (a test used to measure the amount of thyroid stimulating hormone in your blood; high levels indicate underactive thyroid) result dated 02/04/22 revealed the result was abnormal high at 4.65 ml/UL (reference range 0.46-4.60). Observation of the medication pass for Resident #5 on 06/02/22 at 7:57am revealed: -The medication aide (MA) administered one levothyroxine 50mcg tablet with four other medications. -The other medications administered included Eliquis (used as a blood thinner), escitalopram (used to treat depression), PreserVision Areds (an over-the-counter eye vitamin and mineral supplement used to help reduce the risk of progression in patients with moderate to advanced age-related macular degeneration), and vitamin D3 (used to supplement vitamin D levels). Review of Resident #5's April 2022 electronic	D 358		

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D 358	Continued From page 8 Medication Administration Record (eMAR) revealed: -There was an entry for levothyroxine 50mcg one tablet daily scheduled at 8:00am. -The levothyroxine was documented as administered 04/01/22 to 04/30/22. Review of Resident #5's May 2022 eMAR revealed: -There was an entry for levothyroxine 50mcg one tablet daily scheduled at 8:00am. -The levothyroxine was documented as administered 05/01/22 to 05/31/22. Review of Resident #5's June 2022 eMAR revealed: -There was an entry for levothyroxine 50mcg one tablet daily scheduled at 8:00am. -The levothyroxine was documented as administered on 06/01/22 and 06/02/22. Telephone interview with the facility's contracted pharmacy pharmacist on 06/02/22 at 11:23am revealed: -Absorption of the levothyroxine may be decreased when administered with food or other medications. -However, if the levothyroxine was routinely administered with other medications and TSH levels were being checked regularly, he did not recommend changing the way it was being administered. -Administering Eliquis, escitalopram, PreserVision Areds, or vitamin D3 along with levothyroxine may decrease the absorption of levothyroxine but would not decrease the effectiveness of the other medications. Interview with a medication aide (MA) on 06/02/22 at 1:40pm revealed:	D 358		

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D 358	Continued From page 9 -When she administered morning medications, she administered the levothyroxine 30 minutes before Resident #5 ate. -She did not administer the levothyroxine with other medications. Telephone interview with the Administrator on 06/02/22 at 3:06pm revealed: -The MA should have administered the levothyroxine separate from the other medications and 30 minutes before other medications as it was ordered. -The Director of Nursing (DON) or MAs would have been responsible for scheduling the other morning medications to be administered later in the morning on the eMAR. Attempted interview with Resident #5's PCP on 06/02/22 at 11:06am was unsuccessful. Based on observations, interviews, and record review it was determined Resident #5 was not interviewable.	D 358		
D 618	10A NCAC 13F .1802 (a) Report & Notification of a Outbreak (temp) 10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK (a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in Rules 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including	D 618		

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D 618	Continued From page 10 subsequent amendments. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report confirmed cases of COVID-19 to the local health department (LHD) immediately upon finding out a resident had tested positive for COVID-19. The findings are: Review of CDC Guidance Interim Infection Prevention and Control Recommendations to COVID-19 spread in Nursing Homes and Long-Term Care Facilities dated 02/02/22 revealed notify the LHD promptly of 1 resident or staff with suspected or confirmed SARS-CoV-2 infection. Review of a memo from the NC Department of Health and Human Services (NCDHHS) Division of Health Service Regulation (DHSR) dated 11/21/22 revealed: -The Adult Care Home Administrator or his/her designee must report all suspected communicable disease outbreaks to the local health department. -A suspected communicable disease outbreak is defined as any illnesses among residents with same identifiable infectious cause (e.g. evidence of the same virus found on laboratory testing). -Reports must be made by phone within 24 hours of the time when the outbreak is reasonably suspected to exist. Interview with the facility's Director of Nursing (DON) on 06/01/22 at 9:20am revealed: -The facility had two resident confirmed cases of	D 618		

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D 618	Continued From page 11 COVID-19 in the facility. -The first resident tested positive on 05/25/22. -The second resident tested positive on 05/26/22. -She had not reported the resident cases of COVID-19 to the LHD. -She thought there had to be at least 3 confirmed cases of COVID-19 before reporting to the LHD as an outbreak. Telephone interview with the LHD nurse on 06/02/22 at 10:12am revealed: -She was not aware two residents had tested positive for COVID-19 at the facility. -The facility was not listed on their list as in current outbreak status for COVID-19. -The facility staff should have reported the first positive COVID test on 05/25/22 within 24 hours. -The facility staff should have reported the second positive COVID test on 05/26/22 within 24 hours. -They had communicated guidance on how to handle COVID-19 cases to facility staff during a recent COVID-19 outbreak earlier in the year in the facility. A second interview with the DON on 06/02/22 at 10:30am revealed: -All of the residents were fully vaccinated with the exception of one resident out of 25 residents. -All of the staff were fully vaccinated and boosted. -Residents were screened daily for symptoms of COVID-19. -Staff were screened daily upon arrival for their shift. -All visitors were screened at the entrance. -The first positive case occurred on 05/25/22. -The resident had been rapid tested due to the resident complaining of COVID-19 like symptoms. -Once the resident was discovered to be positive,	D 618			

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D 618	Continued From page 12 the resident was placed in isolation (the resident lived in a private room). -On 05/25/22, they tested all residents and staff who had contact with the positive resident. -In all they tested 16 residents and staff on 05/25/22 and they all tested negative for COVID-19 except for the one resident. -They discontinued communal dining on 05/25/22. -They began using disposables for meal services on 05/25/22. -Telehealth visits were immediately implemented whenever possible on 05/25/22. -On 05/26/22, all the other residents and staff who had not been tested on 05/25/22 were tested. -A second resident tested positive on 05/26/22. -The second resident who tested positive was immediately placed in isolation (the resident lived in a private room). -All the other COVID-19 tests completed on 05/26/22 were negative. -All residents and staff were retested on 05/30/22 and the tests were all negative. -All resident and staff were scheduled to be retested on 06/03/22. Telephone interview with the Administrator on 06/02/22 at 3:06pm revealed: -The DON was responsible for reporting of positive COVID-19 cases to the LHD. -The DON should have reported the first positive COVID-19 case to the LHD within 24 hours as per policy.	D 618		