STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 survey on December 6 - 9, 2022.	D 000		
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: Based on interviews and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs of 1 of 5 sampled residents (Resident #2) with new physician's orders and an endocrinology consultation completed on 09/22/22, not followed up on by the facility until 10/28/22. The findings are: 1. Review of Resident #2's current FL2 dated 11/01/22 revealed diagnoses included type II diabetes mellitus, hypertension, hyperlipidemia, osteoarthritis, obstructive sleep apnea (COPD), coronary artery disease (CAD), chronic constipation, paroxysmal atrial fibrillation, and chronic respiratory failure. Review of Resident #2's record revealed her hemoglobin A1c was 12.3% on 07/29/22 and 11.9% on 09/22/22. Review of Resident #2's record revealed: -There was a 10 page fax dated 10/28/22 for an Endocrinology consultation that was completed on 09/22/22. -The facility's Director of Nursing (DON) received the faxed consultation note, documented as	D 273	Appointments will be tracked by the Executive Director (ED)/Health Services Director (HSD) or designee. When a resident returns from an appointment, the HSD or designee will request paperwork from that physician or office that day. If there is no response from the physician in 3 days, a second attempt will be made by the HSD/designee to get the records. Attempts to retrieve documentation from appointments will be documented. Orders received in the consultation paperwork will be shared with the PCP, and faxed to the pharmacy for entry into the eMAR. The HSD/designee will audit 10% of physician orders each month to assure compliance with processing and following orders.	2/3/2023

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D 273	Continued From page 1	D 273		

"urgent" on 10/28/22 at 10:27am from the endocrinologist's nurse.
-The endocrinologist's progress note (only 6 pages) was faxed to the facility's contracted pharmacy on 10/28/22 at 11:30am.
-The assessment was documented as type II diabetes mellitus without complication, without long term current use of insulin (a medication used to treat high blood sugar) - uncontrolled.
-The plan was to start Tresiba 200 unit/ml injection, inject 60 units subcutaneously (SQ) daily; start Humalog Kwik Pen (a fast acting insulin used to treat high blood sugar) 1 unit 100 units/ml, inject 33 units before meals plus Humalog sliding scale insulin (SSI).
-Sliding scale insulin as follows: check finger stick blood sugars (FSBS) before each meal and at bedtime; correct high blood sugars taken before meals based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10 units and call into clinic if blood sugars do not come down after 1-2 hours.
-Call the office if your blood sugars are below 70 mg/dl or greater than 300mg/dl more than 3 times per week.
-Discontinue Levemir and regular insulin.
-Hemoglobin A1c was documented as 11.9%, the goal A1c is 7%.
-Glycemic control documented as "worse based on A1c of 11.9%".

a. Review of Resident #2's current FL2 dated 11/01/22 revealed:
-There was an order for Levemir inject 30 units SQ twice daily.
-There was an order to check FSBS three times a day, notify provider for FSBS <60 or >400.

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	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

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THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 273	Continued From page 2 Review of Resident #2's physician's orders dated 11/10/22 revealed Levemir inject 30 units SQ twice daily was discontinued. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed there was an entry for Levemir inject 30 units SQ twice daily, scheduled for 7:30am and 8:00pm. Review of Resident #2's November 2022 eMAR revealed there was not an entry for Levemir inject 30 units SQ twice daily. b. Review of Resident #2's current FL2 dated 11/01/22 revealed: -There was an order for Novolin R 100units/ml inject 33 units SQ three times daily before meals. -There was an order to check FSBS three times a day, notify provider for FSBS <60 or >400. Review of Resident #2's physician's orders dated 11/10/22 revealed Novolin R 100units/ml inject 33 units SQ three times daily before meals was discontinued. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novolin R 100units/ml inject 33 units SQ three times daily before meals. -Novolin R was documented as discontinued on 10/31/22. -There was an entry to check FSBS three times a day, notify provider for FSBS <60 or >400. Review of Resident #2's November 2022 eMAR revealed -There was not an entry for Novolin R 100units/ml	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 273	Continued From page 3 inject 33 units SQ three times daily before meals. -There was an entry to check FSBS three times a day, notify provider for FSBS <60 or >400. -There was no PCP notification of FSBS >400 results on 11/04/22 of 417 at 4:38pm, 11/13/22 of 461 at 6:17am, and 11/26/22 of 426 at 4:26pm. c. Review of Resident #2's physician's orders dated 11/10/22 revealed: -There was an order for Humalog 100 unit/ml Kwik Pen, with a start date of 10/31/22 and end date of 11/02/22, check FSBS before meals and at bedtime and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if FSBS does not come down after 1-2 hours. There was also a comment for this entry "discontinued from 11/02/2022". -There was an order for Humalog 100 unit/ml Kwik Pen, with a start date of 11/08/22, check FSBS before meals and at bedtime and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours, scheduled for 6:00am, 11:30am, 4:30pm, and 8:00pm. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Humalog 100 unit/ml Kwik Pen, with a start date of 10/31/22, check FSBS before meals and at bedtime and administer SSI based on the following FSBS:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

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D 273	Continued From page 4	D 273		

171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours, scheduled for 6:00am, 11:00am, 4:00pm, and 8:00pm.
-Humalog 100 unit/ml Kwik Pen sliding scale insulin was documented as "not recorded" at 8:00pm on 10/31/22.

Review of Resident #2's November 2022 eMAR revealed:
-There was an entry for Humalog 100 unit/ml Kwik Pen, with a start date of 10/31/22 and discontinued date of 11/02/22, check FSBS before meals and at bedtime and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours, scheduled for 6:00am, 11:00am, 4:00pm, and 8:00pm.
-Humalog 100 unit/ml Kwik Pen sliding scale insulin was documented as administered on 11/01/22 at 11:00am and 8:00pm.
-Humalog 100 unit/ml Kwik Pen sliding scale insulin was documented as not administered on 11/01/22 at 6:00am and 4:00pm.
-There was an entry for Humalog 100 unit/ml Kwik Pen, with a start date of 11/08/22 and discontinued date of 11/16/22, check FSBS before meals and at bedtime and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

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THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 273	Continued From page 5	D 273		

sugar does not come down after 1-2 hours, scheduled for 6:00am, 11:30am, 4:30pm, and 8:00pm.
-Humalog Kwik Pen sliding scale insulin was documented as administered on 11/09/22 at 11:30am to 11/16/22 at 6:00am.
-Humalog Kwik Pen sliding scale insulin was documented as not administered on 11/11/22 at 11:30am, 4:30pm, and 8:00pm due to medication not available.
-There was an entry to check FSBS three times a day, notify provider for FSBS <60 or >400.

d. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order with a start date of 11/02/22 for NovoLog (a fast acting insulin used to treat high blood sugar) 100 unit/ml Flex Pen check FSBS and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours, scheduled for 6:00am, 11:30am, 4:30pm, and 8:00pm. There was a comment for this entry "discontinued from 11/09/2022".

Review of Resident #2's pharmacy memo to facility/prescriber dated 11/14/22 revealed on 11/14/22 the endocrinologist signed the pharmacy memo to change the order for Humalog to Novolog sliding scale insulin.

Review of Resident #2's November 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for NovoLog 100 unit/ml Flex Pen, with a start date of 11/02/22 and discontinued date of 11/09/22, check FSBS and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 273	Continued From page 6 administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours, scheduled for 6:00am, 11:30am, 4:30pm, and 8:00pm. -NovoLog Flex Pen sliding scale insulin was documented as administered from 11/02/22 at 6:00am to 11/09/22 at 6:00am. -There was a second entry for NovoLog 100 unit/ml Flex Pen, with a start date of 11/15/22, check FSBS before meals and at bedtime and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours, scheduled for 8:00am, 12:00pm, 5:00pm, and 9:00pm. -NovoLog Flex Pen sliding scale insulin was documented as administered from 11/16/22 at 8:00am to 11/30/22 at 9:00pm. -NovoLog Flex Pen sliding scale insulin was documented as "not recorded" on 11/19/22 at 8:00am, 5:00pm, and 9:00pm; 11/20/22 at 5:00pm and 9:00pm, 11/23/22 at 8:00am, and 11/29/22 at 12:00pm. Review of Resident #2's December 2022 eMAR revealed: -There was an entry for NovoLog 100 unit/ml Flex Pen, check FSBS before meals and at bedtime and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 273	Continued From page 7	D 273		

call doctor if blood sugar does not come down after 1-2 hours, scheduled for 8:00am, 12:00pm, 5:00pm, and 9:00pm.
-NovoLog Flex Pen sliding scale insulin was documented as administered from 12/01/22 at 8:00am to 12/08/22 at 8:00am.
-There was a second entry for NovoLog 100 unit/ml Flex Pen, check FSBS before meals and at bedtime and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours, scheduled for 8:00am, 12:00pm, 5:00pm, and 9:00pm.
-NovoLog Flex Pen sliding scale insulin was documented as administered from 12/08/22 at 12:00pm to 12/09/22 at 8:00am.

e. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for Tresiba Flex Pen (a long acting insulin used to treat high blood sugar) 200 units, inject 60 units SQ daily at 8:00am.

Review of Resident #2's November 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Tresiba Flex Pen 200 units, inject 60 units SQ every morning with a start date of 10/29/22.
-Tresiba 60 units was documented as administered daily from 11/01/22 to 11/30/22.

Telephone interview with Resident #2's PCP on 12/08/22 at 11:40am revealed:
-She last saw Resident #2 on 09/06/22.
-She made a referral for her to see the endocrinologist on 09/22/22.

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	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 273	Continued From page 8 -The endocrinologist visit note should have been followed up on by the facility. -It was the facilities responsibility to follow-up on any consultations and ask for clarifications of orders. -Per her review of the endocrinologists visit note dated 09/22/22 Resident #2 should have been started on Humalog 33 units SQ three times a day and Humalog sliding scale insulin based on FSBS results SQ before meals with FSBS obtained before meals and at bedtime, and Tresiba 60 units SQ daily. -The PCP never received the endocrinologist's note, but was able to review it today (12/08/22). -Resident #2's Levemir and Novolin R should have been discontinued when Tresiba was started. -The referral was made because Resident #2 was a poorly controlled diabetic, who was non-compliant with diet. Interview with the Corporate Registered Nurse (RN) on 12/08/22 at 3:00pm revealed: -The endocrinologist visit note from 09/22/22 was not signed by the physician and should not have been considered as an order. -The visit note would normally be faxed to the pharmacy, and then the pharmacy would send back to the facility and the PCP for a signature. -The Director of Nursing (DON) was responsible to follow-up with the endocrinologist after 09/22/22 and keep the visit note in a folder until the physician sent signed orders. -The Corporate Nurse RN had been working in the facility 4 days per week doing chart audits, and had not audited Resident #2's record yet. -She was not aware that the 09/22/22 visit notes had not been received by the facility until 10/28/22 when the DON requested them from the endocrinologist.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 273	Continued From page 9	D 273		

Interview with a pharmacy technician from the facility's contracted pharmacy on 12/8/22 at 3:25pm revealed:
-They had received a 6 page document from the endocrinologist visit made on 09/22/22 for Resident #2 at the end of October 2022, and used the document as physician orders.
-She did not realize she was missing 4 pages and that it was not signed by the physician.

Interview with Resident #2 on 12/08/22 at 3:45pm revealed:
-She saw the endocrinologist on 09/22/22 via non-facility transport.
-She knew she was receiving insulin but uncertain what type of insulin.
-She knew her insulin was supposed to be "changed around".

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/08/22 at 2:57pm revealed:
-If the resident received too little insulin, then the resident's FSBS could continue to increase causing nausea, hyperglycemia, headache, increased blood pressure, increased thirst and blurred vision.
-If the resident did not receive enough insulin, then the resident's FSBS could decrease causing symptoms of hypoglycemia such as sweating, nausea, headache, difficulty breathing, heart palpations, anxiety, shakiness and lightheadedness.

Telephone interview with the Director of Nursing (DON) on 12/09/22 at 1:42pm revealed:
-The endocrinology consultation for Resident #2 was completed on 09/22/22 and had "slipped her mind" due to other responsibilities in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 273	Continued From page 10 -The endocrinology office had never sent the visit notes to the facility. -She had asked Resident #2 about the visit on 09/22/22 in mid-October 2022 and the resident told her she didn't know what happened to the paperwork, but that a local pharmacy had called the resident soon after her visit and said they had medications for her. She did not tell anyone about that phone call until the DON brought up the visit with her in mid-October. -The DON then contacted the endocrinology office and requested the visit notes be sent to the facility from the 09/22/22 consult. -The notes were faxed to the DON's attention on 10/28/22 and she immediately faxed the 10 page document to the facility's contracted pharmacy. -The DON requested signed physician orders from the endocrinologist, but never received them, so the facility used the 10-page document from the endocrinologist as physician orders. -She was responsible to follow-up on orders entered by the pharmacy, and if the MAs had an issue with medication orders or instructions for administration, they were to report them to her. Interview with the Administrator on 12/09/22 at 12:30pm revealed: -The DON was responsible to follow-up on the 09/22/22 endocrinology consultation for Resident #2. -She did not know when Resident #2's endocrinology consultation notes were actually sent to the facility. Attempted telephone interview with Resident #2's endocrinologist on 12/09/22 at 9:24am was unsuccessful.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 276	Continued From page 11	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure documentation and implementation of written procedures, treatments or orders from a physician and other licensed health professionals for 2 of 5 sampled residents (Resident #1 and #5) related to medications to treat diarrhea, pain, and fever (#1) and medications to treat chronic joint pain (#5). The findings are: 1. Review of Resident #5's current FL2 dated 07/12/22 revealed: -Diagnoses included fracture of upper and lower end fibula, difficulty walking, muscle weakness and lack of coordination. -There was an order for tramadol 50mg (to treat pain) by mouth twice daily as needed for pain. Review of a subsequent physician order dated 09/06/22 revealed an order for tramadol 50mg by mouth twice daily. Review of a subsequent physician order dated 11/03/22 revealed an order for tramadol 50mg by mouth twice daily.	D 276	When a physician's order is received, the order will be faxed to the pharmacy, marked as faxed and placed in a file. The pharmacy will enter the order into the eMAR and the HSD or designee will process the order. The HSD or designee will audit the file of faxed orders at least 3 times per week to ensure they are in the EMAR and accurate.	2/3/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 276	Continued From page 12 Review of Resident #5's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for tramadol 50mg by mouth twice daily documented as administered 11/01/22 to 11/04/22 at 8:00am and 6:00pm. -The tramadol was documented as not administered from 11/05/22 to 11/31/22. -The tramadol was documented as not administered from 11/09/22 to 11/31/22. -Tramadol was documented on the eMAR as being discontinued on 11/04/22. Review of Resident #5's November 2022 controlled substance count sheet revealed tramadol 50mg by mouth twice daily was documented as administered from 11/05/22 to 11/08/22. Review of Resident #5's December 2022 eMAR revealed there was no entry for tramadol 50mg by mouth twice daily. Observation of Resident #5's medications available for administration on 12/07/22 at 12:12pm revealed: -A bubble pack of tramadol 50mg with a printed label indicating 30 tablets were dispensed on 11/03/22 with 30 tablets remaining on the medication cart. -A bubble pack of tramadol 50mg with a printed pharmacy label indicating 30 tablets were dispensed on 11/03/22 with 5 tablets remaining. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 12/07/22 at 2:58pm revealed: -Tramadol 50mg was last filled on 11/03/22 from a prescription dated 09/06/22 with three refills.	D 276		

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D 276	Continued From page 13 -On 11/03/22, they received an order for tramadol 50mg twice daily. -The pharmacy discontinued the previous tramadol order dated 09/06/22. -When the new prescription was received, the pharmacy sent the facility a request to process the prescription via the eMAR system on 11/03/22. -The request was not processed or approved by the facility. Interview with Corporate Registered Nurse on 12/08/22 at 10:30am revealed: -She knew the order for tramadol should have been processed when the pharmacy sent it. -She did not know why it was not processed. Interview with Resident #5 on 12/08/22 at 10:45am revealed: -She was not aware she was not receiving tramadol. -She experienced pain frequently. -She asked the MA for pain medication and was not administered the tramadol. -She was given something for pain but did not know what medication she had received. Interview with medication aide (MA) on 12/08/22 at 10:40am revealed: -She was not aware that resident #5 received an order for tramadol and was not processed. -Resident #5 verbalized pain and requested pain medication. -She did not administer tramadol from 11/08/22 to 12/09/22. -She did administer baclofen (used to help relax muscles) 10mg by mouth daily to Resident #5. -The baclofen 10mg was effective to ease Resident #5's pain symptoms.	D 276		

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D 276	Continued From page 14 Telephone interview with PCP on 12/08/22 at 12:12pm revealed: -She did not know Resident #5 was not receiving tramadol. -Resident #5 was ordered tramadol due to chronic joint pain. -Resident #5's pain was well controlled when taking tramadol. -If the tramadol was stopped suddenly, the resident could experience grogginess, unsteadiness, pain, and runny nose due to tramadol being an opioid. Interview with the Administrator on 12/08/22 at 2:50pm revealed: -She did not know that Resident #5 had not been receiving tramadol. -She did not know that Resident #5's order for tramadol had not been processed by the facility. Interview with Corporate Registered Nurse on 12/08/22 at 3:10pm revealed: -The facility had a folder for the PCP to leave any information, orders, or paperwork when PCP was in the facility. -Clinical staff were to review PCP folder after every PCP visit. -Clinical staff were to implement any orders left by the PCP. -Clinical staff were to fax any new prescriptions orders to the pharmacy. -She expected nursing staff should follow up with any orders faxed to the pharmacy if there was no response from the pharmacy. -Clinical staff were to place any new orders in the resident's charts after implementation. -When orders were written by the PCP, orders were to be faxed to both the pharmacy. -Clinical were to process any orders to discontinue medications.	D 276		

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D 276	Continued From page 15 Refer to the interview with the Administrator on 12/08/22 at 2:50pm. Refer to the interview with the Administrator on 12/08/22 at 2:50pm. Refer to review of the facility's Medication Administration Policy dated 08/01/21. 2. Review of Resident #1's current FL2 dated 06/14/22 revealed: -Diagnoses included chronic atrial fibrillation, urinary tract infection, generalized muscle weakness, and right shoulder joint subluxation. -There was an order for acetaminophen (used to treat pain or fever) 650mg by mouth every four hours as needed. Review of Resident #1's signed physician's order dated 08/11/22 revealed: -An order for loperamide HCL (used to treat diarrhea) 2mg by mouth twice daily as needed for loose stools. -An order to discontinue acetaminophen 650mg (used for pain or fever) by mouth every four hours as needed. -An order to start acetaminophen 650mg (used for pain and fever) by mouth twice daily. -An order to start acetaminophen 650mg (used for pain and fever) by mouth every eight hours as needed. Review of Resident #1's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was not an entry for acetaminophen 650mg by mouth twice daily. -There was not an entry for acetaminophen 650mg by mouth every eight hours as needed. -There was an entry for acetaminophen 650mg	D 276		

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D 276	Continued From page 16	D 276		

by mouth every four hours as needed with 24 doses documented as administered 10/01/22 to 10/31/22.
-There was not an entry for loperamide HCL 2mg by mouth twice daily as needed.

Review of Resident #1's November 2022 eMAR revealed:
-There was an entry for acetaminophen 650mg by mouth every four hours as needed with 28 doses documented as administered 11/01/22 to 11/30/22.
-There was not an entry for loperamide HCL 2mg by mouth twice daily as needed.
-There was not an entry for acetaminophen 650mg by mouth twice daily.
-There was not an entry for acetaminophen 650mg by mouth every eight hours as needed.

Review of Resident #1's December 2022 eMAR revealed:
-There was an entry for acetaminophen 650mg by mouth every four hours as needed with 6 doses documented as administered from 12/01/22 - 12/04/22.
-There was not an entry for loperamide HCL 2mg by mouth twice daily as needed.
-There was not an entry for acetaminophen 650mg by mouth twice daily.
-There was not an entry for acetaminophen 650mg by mouth every eight hours as needed.

Interview with the Corporate Registered Nurse on 12/07/2022 at 11:30am revealed:
-She did not know Resident #1 had orders that were not implemented.
-The orders were missed by facility staff and not faxed to the pharmacy.

Review of email addressed to Corporate

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D 276	Continued From page 17 Registered Nurse from Resident #1's PCP on 12/07/22 revealed: -She was made aware of orders given on 08/11/22 by another provider within the same practice for scheduled acetaminophen and loperamide as needed on 12/07/22. -She documented to take verbal order to disregard orders from 08/11/22 and to continue acetaminophen 325mg, 2 tabs (650mg) by mouth every four hours as needed on 12/07/22. Interview with the Corporate Registered Nurse on 12/08/2022 at 3:10pm revealed: -The facility had a folder for the PCP to leave any information, orders, or paperwork when the PCP was in the facility. -The MAs, Assistant DON and DON were responsible for review of the PCP folder after every PCP visit and implement any new orders. -The MAs, Assistant DON and DON were responsible for faxing new prescriptions orders to the pharmacy. -She expected the MAs, Assistant DON and DON to follow up with any orders faxed to the pharmacy if there was no response from the pharmacy. -The MAs, Assistant DON and DON were responsible for placing the new orders in the resident's charts after implementation. Interview with the Administrator on 12/08/22 at 2:50pm revealed: -She did not know Resident #1's physician orders acetaminophen and loperamide were not implemented. -The MAs, Assistant DON and DON were responsible for faxing all orders to the pharmacy. -She did not know why the orders for Resident #1 were missed. -The MAs, Assistant DON and DON were	D 276		

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D 276	Continued From page 18 responsible for implementing and following up on physician orders. Attempted telephone interview with PCP on 12/07/22 at 2:40pm was unsuccessful. Refer to the interview with the Administrator on 12/08/22 at 2:50pm. Refer to review of the facility's Medication Administration Policy dated 08/01/21. Interview with the Administrator on 12/08/22 at 2:50pm revealed: -Clinical staff were responsible for the processing of physician orders. -She expected the staff to ensure all physician orders were processed. Review of the facility's Medication Administration Policy dated 08/01/21 revealed: -Medications would be administered appropriately per state and organizational policies and procedures. -The staff would ensure the administration of medications in accordance with the prescribing practioner's orders. -The resident's electronic Medication Administration Record (eMAR) would be accurate and including: strength, dose or quantity of medication administered; and documentation of any omission and reason for omissions.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

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D 358	Continued From page 19 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 6 sampled residents (Resident #2, #5, and #7) with medication orders for a fast-acting insulin that was administered incorrectly (#2 and #7), a long-acting insulin that was administered without a signed physician's order, a fast acting insulin and long acting insulin that were discontinued without signed physician orders used to treat high blood sugars (#2), and medications to treat pain (#5). The findings are: 1. Review of Resident #2's current FL2 dated 11/01/22 revealed diagnoses included type II diabetes mellitus, hypertension, hyperlipidemia, osteoarthritis, obstructive sleep apnea (COPD), coronary artery disease (CAD), chronic constipation, paroxysmal atrial fibrillation, and chronic respiratory failure. a. Review of Resident #2's physician's orders dated 09/06/22 revealed there was an order for Levemir injection flex-touch (a long-acting insulin used to treat high blood sugar levels) inject 30 units subcutaneously (SQ) twice daily.	D 358	All staff that administer medications will be re-trained by a registered nurse on the following: 1) components of a complete physician's order 2) obtaining clarification on physician's orders 3) administering medications as ordered 4) documentation of medication administration and specific values 5) notification of a resident's physician when values fall outside of specified parameters. The HSD or designee will conduct a monthly audit of diabetic resident records to ensure insulin is being administered as ordered.	1/23/2023

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D 358	Continued From page 20 Review of Resident #2's current FL2 dated 11/01/22 revealed: -There was an order for Levemir inject 30 units SQ twice daily. -There was an order to check finger stick blood sugar (FSBS) three times a day, notify provider for blood sugar <60 or >400. Review of Resident #2's physician's orders dated 11/10/22 revealed Levemir inject 30 units SQ twice daily was discontinued. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Levemir inject 30 units SQ twice daily, scheduled for 7:30am and 8:00pm. -Levemir was documented as administered twice daily from 10/03/22 at 7:30am to 10/29/22 at 7:30am. -Levemir was documented as "not recorded" twice daily from 10/01/22 at 7:30am to 10/02/22 8:00pm. Review of Resident #2's November 2022 eMAR revealed there was not an entry for Levemir inject 30 units SQ twice daily. b. Review of Resident #2's physician orders dated 09/06/22 revealed there was an order for Novolin R (a short-acting insulin used to control elevated blood sugar) 100U/ML inject 33 units SQ three times daily with meals. Review of Resident #2's current FL2 dated 11/01/22 revealed: -There was an order for Novolin R 100U/ML inject 33 units SQ three times daily before meals. -There was an order to check FSBS three times a	D 358		

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D 358	Continued From page 21 day, notify provider for blood sugar <60 or >400. Review of Resident #2's physician orders dated 11/10/22 revealed Novolin R 100U/ML inject 33 units SQ three times daily before meals was discontinued. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novolin R 100U/ML inject 33 units SQ three times daily before meals. -Novolin R was documented as administered 3 times daily from 10/03/22 before breakfast to 10/31/22 before lunch. -Novolin R was documented as "not recorded" from 10/01/22 before breakfast to 10/02/22 before dinner, and on 10/05/22 before lunch. -Novolin R was documented as discontinued on 10/31/22. -There was an entry to check FSBS three times a day, notify provider for blood sugar <60 or >400. -There were no FSBS three times daily documented, only initials that it had been performed. Review of Resident #2's November 2022 eMAR revealed -There was not an entry for Novolin R 100U/ML inject 33 units SQ three times daily before meals. -There was an entry to check FSBS three times a day, notify provider for FSBS <60 or >400. -There was no PCP notification of FSBS >400 results on 11/04/22 of 417 at 4:38pm, 11/13/22 of 461 at 6:17am, and 11/26/22 of 426 at 4:26pm. c. Review of Resident #2's physician's orders dated 11/10/22 revealed: -There was an order for Humalog (a rapid-acting insulin used to control elevated blood sugar)	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 22 100unit/ml Kwik Pen, with a start date of 10/31/22 and end date of 11/02/22, check FSBS before meals and bedtime and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours, which included additional directions to administer at 3 units at 6:00am, 3 units at 11:00am, 3 units at 4:00pm, and 3 units at 8:00pm. -There was a comment for the Humalog entry to be "discontinued from 11/02/2022". -There was a subsequent order for Humalog 100unit/ml Kwik Pen, with a start date of 11/08/22, check FSBS before meals and at bedtime and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours, scheduled for 6:00am, 11:30am, 4:30pm, and 8:00pm. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Humalog 100unit/ml Kwik Pen, with a start date of 10/31/22, check FSBS before meals and at bedtime and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours. -The dose to be administered was entered as "3 units", and was scheduled for 6:00am, 11:00am,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 23 4:00pm, and 8:00pm. -Humalog 100unit/ml Kwik Pen sliding scale insulin was documented as "not recorded" at 8:00pm on 10/31/22. -There were no FSBS three times daily documented, only initials that it had been performed. Review of Resident #2's November 2022 eMAR revealed: - There was an entry for Humalog 100unit/ml Kwik Pen, with a start date of 10/31/22 and discontinued date of 11/02/22, check FSBS before meals and at bedtime and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, blood FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours. -The dose to be administered was entered as "3 units", scheduled for 6:00am, 11:00am, 4:00pm, and 8:00pm. - Humalog 100 unit/ml Kwik Pen sliding scale insulin was documented as administered on 11/01/22 at 11:00am and 8:00pm. - There was a second entry for Humalog 100unit/ml Kwik Pen, with a start date of 11/08/22 and discontinued date of 11/16/22, check FSBS before meals and at bedtime and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours. -The dose to be administered was entered as sliding scale, and was scheduled for 6:00am, 11:30am, 4:30pm, and 8:00pm. - Humalog Kwik Pen sliding scale insulin was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 358	Continued From page 24 documented as administered from 11/09/22 at 11:30am to 11/16/22 at 6:00am. - Humalog Kwik Pen sliding scale insulin was documented as not administered on 11/11/22 at 11:30am, 4:30pm, and 8:00pm due to medication not available. -There was an entry to check FSBS three times a day, notify provider for blood sugar <60 or >400. d. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order with start date documented as 11/02/22 for NovoLog (a rapid-acting insulin used to control elevated blood sugar) 100 unit/ml Flex Pen check blood glucose and administer SSI based on the following FSBS: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours, scheduled for 6:00am, 11:30am, 4:30pm, and 8:00pm. -There was a comment for the NovoLog entry, to be "discontinued from 11/09/2022". Review of Resident #2's pharmacy memo to facility/prescriber dated 11/14/22 revealed on 11/14/22 the endocrinologist signed the pharmacy memo to change the order for Humalog to Novolog sliding scale insulin. Review of Resident #2's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for NovoLog 100 unit/ml Flex Pen, with a documented start date of 11/02/22 and discontinued date of 11/09/22, check FSBS and inject via sliding scale insulin: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 358	Continued From page 25 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours. -The dose to be administered was entered as "sliding scale", scheduled for 6:00am, 11:30am, 4:30pm, and 8:00pm. -NovoLog Flex Pen sliding scale insulin was documented as administered from 11/02/22 at 6:00am to 11/09/22 at 6:00am. -NovoLog Flex Pen sliding scale insulin was documented as "not recorded" on 11/08/22 at 4:30pm, and 8:00pm. -There was a second entry for NovoLog 100unit/ml Flex Pen, with a documented start date of 11/15/22, check FSBS before meals and at bedtime and inject via sliding scale insulin: 171-190=1 units, 191-210=2 units, 211-230=3 units, 231-250= 4 units, 251-270=5 units, 271-290=6 units, 291-310=7 units, 311-330=8 units, 331-350=9 units, FSBS >350=10units and call doctor if blood sugar does not come down after 1-2 hours. -The dose to be administered was entered as "3 INJ", scheduled for 8:00am, 12:00pm, 5:00pm, and 9:00pm. -NovoLog Flex Pen sliding scale insulin was documented as administered from 11/16/22 at 8:00am to 11/30/22 at 9:00pm. -NovoLog Flex Pen sliding scale insulin was documented as "not recorded" on 11/19/22 at 8:00am, 5:00pm, and 9:00pm; 11/20/22 at 5:00pm and 9:00pm, 11/23/22 at 8:00am, and 11/29/22 at 12:00pm. Review of the Resident #2's November and December 2022 vital signs log, compared to the eMARs, progress notes and the med pass reports revealed: -There were no FSBS results documented on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 358	Continued From page 26 11/20/22 at 7:00am, 11/29/22 at 11:30am, 11/08/22 and 11/19/22 at 4:30pm, 11/08/22 at 8:00pm, 11/17/22-11/20/22 at 8:00pm, and 11/23/22-11/25/22 at 8:00pm. -There were no FSBS results documented on 12/02/22 at 8:00pm and 12/06/22 at 8:00pm. -There was no documentation of sliding scale insulin amount administered on 11/19/22 and 11/23/22 at 7:00am, 11/12/22 and 11/29/22 at 11:30am, 11/01/22, 11/08/22, 11/20/22, 11/21/22, and 11/22/22 at 4:30pm. -The incorrect amount of sliding scale insulin was documented as administered from 11/01/22 to 11/30/22 for 29 occurrences out of 120 opportunities. -The incorrect amount of sliding scale insulin was documented as administered from 12/01/22 to 12/08/22 for 12 occurrences out of 32 opportunities. Interview with the facility's Corporate Registered Nurse (RN) on 12/07/22 at 10:45am revealed: -She did not know the Novolog SSI entry dose to be administered was transcribed incorrectly on the November 2022 eMAR for Resident #2. -She did not know the Humalog SSI entry dose to be administered was transcribed incorrectly on the October and November 2022 eMARs for Resident #2. -The new eMAR system used the previous eMAR system orders and when they were combined, the orders did not come across correctly. Interview with the medication aide (MA) on 12/09/22 at 11:43am revealed -On 11/26/22, 11/27/22, 11/29/22,11/30/22, 12/01/22 and 12/02/22, she administered Novolog 3 units instead of Novolog insulin per the sliding scale because of the way the order was entered into the eMAR.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

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THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 358	Continued From page 27 -She did not know the Novolog dose of 3 units was incorrect, and was following the instructions on the eMAR instead of the pharmacy label. -It was not administered correctly until 12/09/22 when the order was entered to administer the Novolog dose via sliding scale. -On 12/09/22, she administered Novolog to Resident #2 per the sliding scale as instructed in the eMAR and on the pharmacy label. e. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order with a start date of 10/29/22 for Tresiba Flex Pen 200 units, inject 60 units SQ daily at 8:00am. Review of Resident #2's record revealed: -There was a 10 page fax dated 10/28/22 related to an Endocrinology consultation that was completed on 09/22/22. -The facility's Director of Nursing (DON) received the fax, documented as "urgent", on 10/28/22 at 10:27am from the endocrinologist's nurse. -The endocrinologist's consultation note (only 6 pages per the fax confirmation sheet) was faxed to the facility's contracted pharmacy on 10/28/22 at 11:30am. -The consultation note was not signed by the physician, nor was there an electronic signature. -The plan was to start Tresiba 200 unit/ml injection, inject 60 units subcutaneously (SQ) daily, and discontinue Levemir and regular insulin. -There was no signed physician's order for Tresiba Flex Pen 60 units SQ daily prior to 11/10/22. Review of Resident #2's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Tresiba Flex injection 200	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 358	Continued From page 28	D 358		

unit, inject 60 units SQ every morning, with a start date of 10/29/22.
-Tresiba 60 units was documented as administered daily from 11/01/22 to 11/30/22.

Interview with the Corporate Nurse on 12/08/22 at 3:00pm revealed:
-Resident #2's endocrinologist visit note dated 09/22/22 was not signed and should not have been considered as an order.
-The visit note would normally be faxed to the pharmacy, and then the pharmacy would send back to the facility and the PCP for a signature.
-The Director of Nursing (DON) was responsible to follow up with the endocrinologist and hold the visit note in a folder until the physician sent signed orders.
-She had been working in the facility 4 days per week doing chart audits, and had not audited Resident #2's record yet.
-She was not aware that the 09/22/22 endocrinologist consultation notes had not been received by the facility until 10/28/22 when the DON requested them from the endocrinologist.

Interview with a pharmacy technician from the facility's contracted pharmacy on 12/8/22 at 3:25pm revealed:
-Tresiba was dispensed on 10/28/22 for a 9ml/15 day supply for a quantity of 3 pens.
-Humalog was switched to Novolog on 11/01/22 for the 33 units TID dose and on 11/15/22 for the sliding scale dose for administration before meals and at bedtime (AC/HS).
-Novolog 100u/ml was dispensed on 11/15/22, for 15 pens/11 day supply, for the 33 units SQ three times daily dose and per sliding scale insulin ACHS.
-She received a note and a verbal order on 10/28/22 from the facility nurse to add Tresiba

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 358	Continued From page 29 and discontinue Levemir and Novolin R. -She had received a 6 page document from the facility at the end of October, related to the endocrinologist consultation on 09/22/22 for Resident #2, and used the document as physician orders. -She did not realize she was missing 4 pages of the 10 page document and that it was not signed by the physician. Further review of Resident #2's record revealed: -There was a Return of Drugs form for Levemir FlexTouch, that were returned to the pharmacy on 10/30/22 for a quantity of 3 pens. -The return reason was documented as discontinued drugs. -The form was signed on 10/30/22 by a medication aide (MA) and the pharmacy courier. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/08/22 at 2:57pm revealed: -If the resident received a decreased dose of insulin, the FSBS could continue to increase resulting in nausea, hyperglycemia, headache, increased blood pressure, increased thirst and blurred vision. -If the resident received an increased dose of insulin, the FSBS could decrease resulting in symptoms of hypoglycemia, which include sweating, nausea, headache, difficulty breathing, heart palpitations, anxiety, shakiness and lightheadedness. Interview with the Administrator on 12/09/22 at 12:30pm revealed: -The DON was responsible to follow-up on the endocrinology consultation completed on 09/22/22 for Resident #2. -She did not know when Resident #2's	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 358	Continued From page 30 endocrinology consultation notes were sent to the facility and was not aware that the consultation notes were not received in a timely manner. Telephone interview with the Director of Nursing (DON) on 12/09/22 at 1:42pm revealed: -She started as the DON on 06/13/22 was on leave since 11/10/22. -The endocrinology consultation for Resident #2 was completed on 09/22/22 and had "slipped her mind" due to other responsibilities in the facility. -The endocrinology office had never sent the visit notes to the facility. -She had asked Resident #2 about the visit on 09/22/22 in mid-October 2022 and the resident told her she didn't know what happened to the paperwork, but that a local pharmacy had called her soon after her visit and said they had medications for her. -The resident did not tell anyone about that phone call until the DON brought up the visit with her in mid-October. -The DON then contacted the endocrinology office and requested the visit notes be sent to the facility from the 09/22/22 consult. -The notes were faxed to the DON's attention on 10/28/22 and she immediately faxed the 10 page document to the facility's contracted pharmacy. -She requested signed physician orders from the endocrinologist, but never received them, so the facility used the 10-page document from the endocrinologist as physician orders. -The pharmacy entered the orders into the system, but they were incorrect, and she had to make multiple corrections in the facility's eMAR system. -The pharmacy had entered the Humalog and Novolog dose descriptions as 1 injection/unit and 3 injections/units. -She had discontinued the Novolin R and Levemir	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 358	Continued From page 31	D 358		

in the eMAR, because the pharmacy would not remove them.
-She was responsible to follow-up on orders entered by the pharmacy, and if the MAs had an issue with a medication orders or instructions for administration, they would report it to her.

Interview with the Assistant DON on 12/09/22 at 3:15pm revealed:
-In September 2022, a new eMAR system was implemented.
-She did not complete any of the medication cart audits which would have shown the medication orders for Resident #2 were incorrect.
-The new system incorporated the old system orders and the new system did not have complete or accurate orders related to Resident #2's insulin.

Telephone interview with Resident #2's PCP on 12/08/22 at 11:40am revealed:
-She last saw Resident #2 on 09/06/22.
-She made a referral for her to see the endocrinologist on 09/22/22.
-The endocrinologist consultation note should have been followed up on by the facility.
-It was the facility's responsibility to follow-up on any consultations and ask for clarifications of orders.
-The PCP never received the endocrinologist's consultation note, but was able to review it today (12/08/22) during the phone interview.
-Per her review of the endocrinologists consultation note dated 09/22/22, Resident #2 should have been started on Humalog 33 units SQ three times a day and Humalog sliding scale insulin based on FSBS results SQ before meals with FSBS obtained before meals and at bedtime, and Tresiba 60 units SQ daily.
-Resident #2's Levemir and Novolin R should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 358	Continued From page 32	D 358		

have been discontinued when Tresiba was started.
-The referral was made because Resident #2 was a poorly controlled diabetic, who was non-compliant with diet.

Attempted telephone interview with Resident #2's endocrinologist on 12/09/22 at 9:24am was unsuccessful.

Refer to interview with the Corporate Nurse on 12/07/22 at 10:45am.

Refer to interview with the (MA) on 12/09/22 at 11:43am.

Refer to interview with the Assistant DON on 12/09/22 at 3:15pm.

Refer to interview with the Administrator on 12/09/22 at 3:35pm.

Review of the facility's Medication Administration Policy.

2. Review of Resident #5's current FL2 dated 07/12/22 revealed:
-Diagnoses included fracture of upper and lower end fibula, difficulty walking, muscle weakness and lack of coordination.
-There was an order for tramadol 50mg (a medication used to treat pain) by mouth twice daily as needed for pain.

Review of a subsequent physician order dated 09/06/22 revealed an order for tramadol 50mg by mouth twice daily.

Review of a subsequent physician order dated 11/03/22 revealed an order for tramadol 50mg by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 358	Continued From page 33 mouth twice daily. Review of Resident #5's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for tramadol 50mg by mouth twice daily documented as administered 11/01/22 to 11/04/22 at 8:00am and 6:00pm. -The tramadol was documented as not administered from 11/05/22 to 11/31/22. -The tramadol was documented as not administered from 11/09/22 to 11/31/22. -Tramadol was documented on the eMAR as being discontinued on 11/04/22. Review of Resident #5's November 2022 controlled substance count sheet revealed tramadol 50mg by mouth twice daily was documented as administered from 11/05/22 to 11/08/22. Review of Resident #5's December 2022 eMAR revealed there was no entry for tramadol 50mg by mouth twice daily. Observation of Resident #5's medications available for administration on 12/07/22 at 12:12pm revealed: -A bubble pack of tramadol 50mg with a printed label indicating 30 tablets were dispensed on 11/03/22 with 30 tablets remaining on the medication cart. -A bubble pack of tramadol 50mg with a printed pharmacy label indicating 30 tablets were dispensed on 11/03/22 with 5 tablets remaining. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 12/07/22 at 2:58pm revealed: -Tramadol 50mg was last filled on 11/03/22 from	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 358	Continued From page 34	D 358		

a prescription dated 09/06/22 with three refills.
-On 11/03/22, they received an order for tramadol 50mg twice daily.
-The pharmacy discontinued the previous tramadol order dated 09/06/22.
-When the new prescription was received, the pharmacy sent the facility a request to process the prescription via the eMAR system on 11/03/22.
-The request was not processed or approved by the facility.

Interview with Resident #5 on 12/08/22 at 10:45am revealed:
-She was not aware she was not receiving tramadol.
-She experienced pain frequently.
-She asked the MA for pain medication and was not administered the tramadol.
-She was given something for pain but did not know what medication she had received.

Interview with medication aide (MA) on 12/08/22 at 10:40am revealed:
-She was not aware that resident #5 received an order for tramadol and was not processed.
-Resident #5 verbalized pain and requested pain medication.
-She did not administer tramadol from 11/08/22 to 12/09/22.
-She did administer baclofen (used to help relax muscles) 10mg by mouth daily.
-She said baclofen 10mg by mouth daily did help ease Resident #5's pain symptoms.
-She knew the order for tramadol should have been processed when the pharmacy sent it.
-She did not know why it was not processed.

Interview with Corporate Registered Nurse on 12/08/22 at 10:30am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 358	Continued From page 35 -She did contact the PCP regarding Resident #5's tramadol not being given. Telephone interview with PCP on 12/08/22 at 12:12pm revealed: -She did not know Resident #5 was not receiving tramadol. -She ordered tramadol for Resident #5 due to chronic joint pain. -Resident #5's pain was well controlled when taking tramadol. -If tramadol was stopped suddenly, the resident could experience grogginess, unsteadiness, pain, and runny nose due to tramadol being an opioid. -On 11/03/22, Resident #5 was seen by another provider within the same practice and a refill of tramadol was provided. Interview with the Administrator on 12/08/22 at 2:50pm revealed: -She did not know that Resident #5 was not receiving tramadol. -She did not know that Resident #5's order for tramadol was not processed by the facility. -The MAs, Assistant Director of Nursing (ADON) and DON were responsible for processing the orders. -She expected the staff to ensure all orders were processed. Refer to interview with the Corporate Nurse on 12/07/22 at 10:45am. Refer to interview with the MA on 12/09/22 at 11:43am. Refer to interview with the Assistant DON on 12/09/22 at 3:15pm. Refer to interview with the Administrator on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 358	Continued From page 36 12/09/22 at 3:35pm. Review of the facility's Medication Administration Policy. 3. Review of Resident #7's current FL2 dated 10/24/22 revealed: -Diagnoses included type 2 diabetes. -An order to check fingerstick blood sugar (FSBS) three times a day. -An order to administer Novolog 100 units/ml insulin (a rapid-acting insulin used to control elevated blood sugar), per the sliding scale: FSBS 0-100= 0 units; FSBS 101-150= 2 units; FSBS 151- 250= 4 units; FSBS 251-400= 8 units; FSBS 401-450= 10 units; if blood sugar is greater than 450 notify the physician. Review of Resident #7's physician's orders dated 10/28/22 revealed: -An order to check fingerstick blood sugar (FSBS) three times daily. -An order to administer Novolog 100 units/ml insulin (a rapid-acting insulin used to control elevated blood sugar), per the sliding scale: FSBS 0-100= 0 units; FSBS 101-150= 2 units; FSBS 151- 250= 4 units; FSBS 251-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units if blood sugar is greater than 450 notify the physician. Review of Resident #7's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was no entry to check FSBS three times daily. -There was no entry to administer Novolog 100 units/ml insulin, per the sliding scale: FSBS 0-100= 0 units; FSBS 101-150= 2 units; FSBS	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 358	Continued From page 37	D 358		

151- 250= 4 units; FSBS 251-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units if blood sugar is greater than 450 notify the physician.

Review of Resident #7's October 2022 Exception Report revealed:
-There was no documentation of a FSBS on 10/28/22 at 8:00am, 12:00pm, 8:00pm, 10/29/22 at 8:00am, 12:00pm, 8:00pm, 10/30/22 at 8:00pm, and 10/31/22 at 8:00am, 12:00pm, 8:00pm.
-There was no documentation of SSI administered on 10/28/22 to 10/31/22 at 8:00am, 12:00pm, 8:00pm.

Review of Resident #7's November 2022 eMAR revealed:
-There was an entry to check FSBS three times daily.
-There was an entry to administer Novolog 100 units/ml insulin, per the sliding scale: FSBS 0-100= 0 units; FSBS 101-150= 2 units; FSBS 151-250= 4 units; FSBS 251-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units if blood sugar is greater than 450 notify the physician was blank on 11/01/22 at 8:00am, 12:00pm and 8:00pm and documented as not administered on 11/25/22 at 8:00am.

Review of Resident #7's November 2022 Exception Report revealed:
-There was no documentation of a FSBS on 11/01/22 at 8:00am, 12:00pm, 8:00pm.
-There was no documentation of SSI administered on 11/01/22 at 8:00am, 12:00pm, 8:00pm.
-There was no documentation of SSI administered for a FSBS of 247 on 11/25/22 at 8:00am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 358	Continued From page 38	D 358		

Review of Resident #7's December 2022 eMAR revealed:
-There was an entry to check FSBS three times daily.
-There was an entry to administer Novolog 100 units/ml insulin, per the sliding scale: FSBS 0-100= 0 units; FSBS 101-150= 2 units; FSBS 151-250= 4 units; FSBS 251-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units if blood sugar is greater than 450 notify the physician documented as administered 12/01/22 to 12/08/22 at 8:00am, 12:00pm and 8:00pm.

Review of Resident #7's Progress Notes from 10/28/22 to 11/08/22 revealed there was no documentation of missed FSBS or insulin administration.

Observation of medications available for administration on 12/09/22 at 11:43am revealed there was a Novolog flex pen 100 units/ml with a printed label indicating 300 units was dispensed on 11/29/22 and 300 units remaining on the medication cart.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/08/22 at 2:57pm revealed:
-There was an order for Novolog 100 units/ml per SSI: FSBS 0-100= 0 units; FSBS 101-150= 2 units; FSBS 151-250= 4 units; FSBS 251-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units if blood sugar is greater than 450 notify the physician documented as administered 12/01/22 to 12/08/22 at 8:00am, 12:00pm and 8:00pm.
-The Novolog was not requested by the facilty staff until 11/28/22 and 5 pens of Novolog 100u/ml containing 300 units/pen was dispensed.
-If the resident received too little insulin, then the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 358	Continued From page 39 resident's FSBS could continue to increase causing nausea, hyperglycemia, headache, increased blood pressure, increased thirst and blurred vision. -If the resident received too much insulin, then the resident's FSBS could decrease causing symptoms of hypoglycemia such as sweating, nausea, headache, difficulty breathing, heart palpations, anxiety, shakiness and lightheadedness. Interview with the (MA) on 12/09/22 at 11:43am revealed she administered sliding scale insulin to Resident #7 based on the scale on the eMAR but did not start the SSI until 11/02/22 because the order was not on the eMAR until then. Refer to interview with the Corporate Nurse on 12/07/22 at 10:45am. Refer to interview with the (MA) on 12/09/22 at 11:43am. Refer to interview with the Assistant DON on 12/09/22 at 3:15pm. Refer to interview with the Administrator on 12/09/22 at 3:35pm. Refer to review of the facility's Medication Administration Policy. Interview with the Corporate Nurse on 12/07/22 at 10:45am revealed: -The MAs were responsible for weekly medication cart audits which was to ensure the medications, eMAR and physician orders all matched. -The Assistant DON and DON was responsible for weekly medication cart audits which was to ensure the medications, eMAR and physician	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 358	Continued From page 40	D 358		

orders all matched.
-If there were any questions or concerns the MA, Assistant DON and DON was responsible for notification to the physician and the pharmacy.
-She did not know the medication cart audits were not completed.
-There was a increased turn over rate with the staff which could be a cause to the audits not being completed.
-She did not know the eMAR was instructing the MAs to give the incorrect amount of insulin for SSI and individual insulin orders.

Interview with the (MA) on 12/09/22 at 11:43am revealed:
-The MAs were responsible for the medications in the medication cart matching the eMAR before they could be administered.
-The MAs, DON and the Assistant DON were responsible for weekly medication cart audits where they would compare the medications to the eMAR and physician orders for accuracy.
-She did not complete a medication cart audit before.
-The new eMAR system used the previous eMAR system orders and when they were combined, the orders did not come across in the correct way.

Interview with the Assistant DON on 12/09/22 at 3:15pm revealed:
-The MAs were responsible for administering medications according to the physician's order.
-The MA was responsible for faxing the orders to the pharmacy.
-The pharmacy was responsible for the orders to be entered into the eMAR system.
-She and the DON were responsible for approving the orders in the eMAR system by verifying the physician order with the order in the eMAR before a medication could be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 358	Continued From page 41 administered. -She and the DON were responsible for reviewing the orders in the eMAR system during the medication cart audits, periodically for accuracy. -She, the MAs and the DON were responsible for order clarifications and documenting in the residents record, but she and the DON were responsible for making sure the clarification were followed up on. -In September 2022, a new eMAR system was implemented. -She was unaware of issues with orders not showing up correctly or completely in the new eMAR system because of the increased turnover rate in staff. -The new system incorporated the old system orders and the new system did not have complete or accurate orders. -She did not complete any of the medication cart audits, which would have shown medication and treatment orders were incomplete and not correct. -The new system incorporated the old system orders and the new system did not have complete or accurate orders related to Resident #2's insulin. Interview with the Administrator on 12/09/22 at 3:35pm revealed: -The MAs were responsible for administering medications according to the physician's order. -The MA was responsible for faxing the orders to the pharmacy. -The pharmacy was responsible for the orders to be entered into the eMAR system. -The Assistant DON and the DON were responsible for approving the orders in the eMAR system by verifying the physician order with the order in the eMAR before a medication could be administered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 358	Continued From page 42 -The Assistant DON and the DON were responsible for reviewing the orders in the eMAR system during the medication cart audits, periodically for accuracy. -The MAs, Assistant DON and the DON were responsible for order clarifications and documenting in the residents record, but she and the DON were responsible for making sure the clarification were followed up on. -In September 2022, the facility switched over to a new eMAR system. -She did not complete any audits after the Assistant DON or DON, or follow up on any of the clinical concerns because she was not clinical and that was the responsibility of the Assistant DON and DON. -She was not aware of any of the issues with medication administration. Review of the facility's Medication Administration Policy dated 08/01/21 revealed: -Medications would be administered appropriately per state and organizational policies and procedures. -The staff would ensure the administration of medications in accordance with the prescribing practioner's orders. -The resident's electronic Medication Administration Record (eMAR) would be accurate and including: strength, dose or quantity of medication administered; and documentation of any omission and reason for omissions. The facility failed to ensure residents medications were administered as ordered for a resident with an order for sliding scale insulin and FSBS that were inaccurately obtained, not documented and insulin incorrectly administered putting the resident at risk for elevated FSBS and uncontrolled diabetic symptoms (#2 and #7) and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 358	Continued From page 43 a resident with an order for pain medication which was not administered for 30 days, causing increased pain without relief (#5) This failure was detrimental to the health of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 23, 2023.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367	All staff administering medications will be re-trained by a registered nurse on documenting omission of medications or treatments and the reason for the omission, including refusals. If there is any issue with the electronic medication administration record, documentation will occur on a paper medication administration record. The HSD/ED or designee will run the "meds not documented report" at least 3 times a week x 4 weeks, 2 times a week x 4 weeks and then weekly, and verify that MARS are accurate and medications are passed as ordered.	2/3/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 44	D 367		

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure the medication administration records (MAR) and electronic medication administrator records (eMAR) were accurate for 4 of 6 sampled residents (#1, #2 #5 and #7).

The findings are:

Review of the facility's Medication Administration policy dated 08/01/21 revealed the resident's Medication Administration Record (MAR) would be accurate and include the following: strength and dosage, or quantity of medication administered, documentation of any omission of medications or treatments, and the reason for the omission.

1. Review of Resident #2's current FL2 dated 11/01/22 revealed diagnoses included type II diabetes mellitus, hypertension, hyperlipidemia, osteoarthritis, obstructive sleep apnea (COPD), coronary artery disease (CAD), chronic constipation, paroxysmal atrial fibrillation, and chronic respiratory failure.

a. Review of Resident #2's physician's orders dated 09/06/22 revealed there was an order for acetaminophen (used to treat mild to moderate pain) 500mg take 2 tablets three times daily.

Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order for acetaminophen 500mg take 2 tablets three times daily for pain.

Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 45 acetaminophen 500mg take 2 tablets three times daily for pain. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for acetaminophen 500mg 2 tablets three times daily scheduled at 8:00am, 2:00pm and 8:00pm. -Acetaminophen 500mg was documented as not recorded on 10/01/22 and 10/02/22 at 8:00am, 2:00pm, and 8:00pm, 10/05/22 at 2:00pm, 10/08/22 at 8:00pm, 10/09/22 at 2:00pm, 10/10/22 at 2:00pm, 10/12/22 at 2:00pm, 10/16/22 at 2:00pm, 10/23/22 at 8:00am, 10/26/22 at 8:00am, and 10/27/22 at 2:00pm. -There were no comments related to why acetaminophen 500mg 2 tablets three times daily was not recorded. Review of Resident #2's November 2022 eMAR revealed: -There was an entry for acetaminophen 500mg 2 tablets three times daily scheduled at 8:00am, 2:00pm and 8:00pm. -Acetaminophen 500mg was documented as not recorded on 11/01/22 at 2:00pm, 11/08/22 at 8:00pm, 11/11/22 at 8:00am, 11/19/22 at 8:00am and 8:00pm, 11/20/22 at 8:00pm, 11/23/22 at 8:00am, 11/29/22 at 2:00pm. -There were no comments related to why acetaminophen 500mg 2 tablets three times daily was not recorded. b. Review of Resident #2's physician's orders dated 09/06/22 revealed there was an order for amlodipine besylate (used to treat high blood pressure) 10mg take one tablet daily for hypertension.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 46 Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order for amlodipine besylate 10mg take one tablet daily. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for amlodipine besylate 10mg take one tablet daily. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for amlodipine 10mg one tablet daily scheduled at 8:00am. -Amlodipine was documented as not recorded on 10/01/22 and 10/02/22. -There were no comments related to why amlodipine 10mg one tablet daily was not recorded. Review of Resident #2's November 2022 eMAR revealed: -There was an entry for amlodipine 10mg one tablet daily scheduled at 8:00am. -Amlodipine 10mg was documented as not recorded on 11/19/22 and 11/23/22. -There were no comments related to why amlodipine 10mg one tablet daily was not recorded. c. Review of Resident #2's physician's orders dated 09/06/22 revealed there was an order for aspirin (used to treat coronary artery disease) 81 mg one tablet daily. Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order for aspirin 81mg one tablet daily. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for aspirin	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 47 81mg one tablet daily. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for aspirin 81mg one tablet daily scheduled at 8:00am. -Aspirin was documented as not recorded on 10/01/22 and 10/02/22. -There were no comments related to why aspirin 81mg one tablet daily was not recorded. Review of Resident #2's November 2022 eMAR revealed: -There was an entry for aspirin 81mg one tablet daily scheduled at 8:00am. -Aspirin was documented as not recorded on 11/19/22 and 11/23/22. -There were no comments related to why aspirin 81mg one tablet daily was not recorded. d. Review of Resident #2's physician's orders dated 09/06/22 revealed there was an order for atorvastatin (used to treat high cholesterol) 80mg one tablet at bedtime. Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order for atorvastatin 80mg one tablet at bedtime. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for atorvastatin 80mg one tablet at bedtime. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for atorvastatin 80mg one tablet daily scheduled at 8:30pm. -Atorvastatin was documented as not recorded on	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 48 10/01/22 and 10/02/22. -There were no comments related to why atorvastatin 80mg one tablet daily was not recorded. Review of Resident #2's November 2022 eMAR revealed: -There was an entry for atorvastatin 80mg one tablet daily scheduled at 8:30pm. -Atorvastatin was documented as not recorded on 11/08/22, 11/19/22 and 11/20/22. -There were no comments related to why atorvastatin 80mg one tablet daily was not recorded. e. Review of Resident #2's physician's orders dated 09/06/22 revealed there was an order for fluticasone spray (used to treat seasonal allergies) 50mcg one spray into each nostril daily. Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order for fluticasone spray 50mcg one spray into each nostril daily. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for fluticasone spray 50mcg one spray into each nostril daily. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for fluticasone spray 50mcg one spray into each nostril daily, scheduled at 8:00am. -Fluticasone was documented as not recorded on 10/01/22 and 10/02/22. -There were no comments related to why fluticasone spray 50mcg one spray into each	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 49	D 367		

nostril daily was not recorded.

Review of Resident #2's November 2022 eMAR revealed:
-There was an entry for fluticasone spray 50mcg one spray into each nostril daily, scheduled at 8:00am.
-Fluticasone was documented as not recorded on 11/19/22 and 11/23/22.
-There were no comments related to why fluticasone spray 50mcg one spray into each nostril daily was not recorded.

f. Review of Resident #2's physician's orders dated 09/06/22 revealed there was an order for furosemide (used to treat excess fluid in the body) 40mg one tablet daily.

Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order for furosemide 40mg one tablet daily.

Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for furosemide 40mg one tablet daily

Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for furosemide 40mg one tablet daily, scheduled at 8:00am.
-Furosemide was documented as not recorded on 10/01/22 and 10/02/22.
-There were no comments related to why furosemide 40mg one tablet daily was not recorded.

Review of Resident #2's November 2022 eMAR revealed:
-There was an entry for furosemide 40mg one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 50 tablet daily, scheduled at 8:00am. -Furosemide was documented as not recorded on 11/19/22 and 11/23/22. -There were no comments related to why furosemide 40mg one tablet daily was not recorded. g. Review of Resident #2's physician's orders dated 09/06/22 revealed there was an order for losartan potassium (used to treat high blood pressure) 100mg take one tablet daily. Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order for losartan potassium 100mg take one tablet daily. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for losartan potassium 100mg take one tablet daily. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for losartan potassium 100mg one tablet daily. -Losartan potassium was documented as not recorded on 10/01/22 and 10/02/22. -There were no comments related to why losartan potassium 100mg one tablet daily was not recorded. Review of Resident #2's November 2022 eMAR revealed: -There was an entry for losartan potassium 100mg one tablet daily. -Losartan potassium was documented as not recorded on 11/19/22 and 11/23/22. -There were no comments related to why losartan potassium 100mg one tablet daily was not recorded.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 51 h. Review of Resident #2's physician's orders dated 09/06/22 revealed there was an order for metoprolol tartrate 25mg (used to treat high blood pressure) take ½ tablet (12.5mg) every 12 hours with food. Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order for metoprolol tartrate 25mg take ½ tablet (12.5mg) every 12 hours with food. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for metoprolol tartrate 25mg take ½ tablet (12.5mg) every 12 hours with food. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metoprolol tartrate 25mg take ½ tablet (12.5mg) every 12 hours with food. -Metoprolol tartrate 25mg was documented as not recorded on 10/01/22 and 10/02/22 at 8:00am and 8:00pm. -There were no comments related to why metoprolol tartrate 25mg take ½ tablet (12.5mg) every 12 hours with food was not recorded. Review of Resident #2's November 2022 eMAR revealed: -There was an entry for metoprolol tartrate 25mg take ½ tablet (12.5mg) every 12 hours with food. -Metoprolol tartrate 25mg was documented as not recorded on 11/08/22 at 8:00am, 11/19/22 at 8:00am and 8:00pm, 11/20/22 at 8:00pm, and 11/23/22 at 8:00am. -There were no comments related to why metoprolol tartrate 25mg take ½ tablet (12.5mg) every 12 hours with food was not recorded.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 367	Continued From page 52 i. Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order for diclofenac gel 1% (used to treat moderate arthritis pain) apply 2 grams to sternal area twice daily. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for diclofenac gel 1% apply 2 grams to sternal area twice daily. Review of Resident #2's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for diclofenac gel 1% apply 2 grams to sternal area twice daily. -Diclofenac was documented as not recorded on 11/08/22 at 8:00pm, 11/19/22 at 8:00am and 8:00pm, 11/20/22 at 8:00pm, and 11/23/22 at 8:00am. -There were no comments related to why diclofenac gel 1% apply 2 grams to sternal area twice daily was not recorded. j. Review of Resident #2's physician's orders dated 09/06/22 revealed there was an order for trazodone (used to treat major depressive disorder) 150mg take one tablet at bedtime. Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order for trazodone 150mg take one tablet at bedtime. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for trazodone 150mg take one tablet at bedtime. Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR)	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 53	D 367		

revealed:
-There was an entry for trazodone 150mg one tablet daily at bedtime.
-Trazodone was documented as not recorded on 10/01/22 and 10/02/22 at 8:00pm.
-There were no comments related to why trazodone 150mg one tablet at bedtime was not recorded.

Review of Resident #2's November 2022 eMAR revealed:
-There was an entry for trazodone 150mg one tablet daily at bedtime.
-Trazodone was documented as not recorded on 11/08/22, 11/19/22, and 11/20/22 at 8:00pm.
-There were no comments related to why trazodone 150mg one tablet at bedtime was not recorded.

k. Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order for oxygen at 3 liters per minute (used to treat low oxygen levels) via nasal cannula continuously.

Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for oxygen at 3 liters per minute via nasal cannula continuously.

Review of Resident #2's November 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for oxygen at 3 liters per minute via nasal cannula continuously with scheduled documentation at bedtime (HS), morning (AM) and evening (PM).
-Oxygen was documented as not recorded on 11/08/22 at PM, 11/09/22 at HS, 11/19/22 at AM and PM, 11/20/22 at HS and PM, 11/21/22 at HS, and 11/23/22 at AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 54 -There were no comments related to why oxygen at 3 liters per minute via nasal cannula continuously was not recorded. I. Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order to check finger stick blood sugar (FSBS) three times daily, notify provider for blood sugar <60 or >400. Review of Resident #2's November 2022 electronic Medication Administration record (eMAR) revealed: -There was an entry to check FSBS three times daily, notify provider for blood sugar <60 or >400. -FSBS three times daily was documented as not recorded from 11/08/22 at 4:30pm, 11/19/22 at 4:30pm, 11/20/22 at 6:30am and 4:30pm, and 11/29/22 at 11:30am. -There were no comments related to why FSBS, three times daily was not recorded. m. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for probiotic (used to promote digestive health) capsule 250mg take one capsule daily. Review of Resident #2's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for probiotic capsule 250mg take one capsule daily. -Probiotic capsule was documented as not recorded on 10/01/22 and 10/02/22. -There were no comments related to why probiotic capsule 250mg take one capsule daily was not recorded. Review of Resident #2's December 2022 eMAR revealed: -There was an entry for probiotic capsule 250mg	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 55	D 367		

take one capsule daily.
-Probiotic capsule was documented as not recorded on 11/19/22 and 11/23/22.
-There were no comments related to why probiotic capsule 250mg take one capsule daily was not recorded.

n. Review of Resident #2's physician's orders dated 09/06/22 revealed there was an order for Levemir injection flex-touch (a long-acting insulin used to treat high blood sugar levels) inject 30 units subcutaneously (SQ) twice daily.

Review of Resident #2's current FL2 dated 11/01/22 revealed there was an order for Levemir injection flex-touch inject 30 units SQ twice daily.

Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Levemir injection flex-touch, inject 30 units SQ twice daily, scheduled at 7:30am and 8:00pm from 10/01/22 to 10/29/22 at 7:30am.
-Levemir was documented as not recorded from 10/01/22 at 7:30am to 10/02/22 at 8:00pm.
-There were no comments related to why Levemir injection flex-touch, inject 30 units SQ twice daily was not recorded.

o. Review of Resident #2's physician's orders dated 09/06/22 revealed there was an order for Novolin R 100 units/ml (a long-acting insulin used to treat high blood sugar levels) inject 33 units subcutaneously (SQ) three times daily with meals.

Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 56 -There was an entry for Novolin R 100U/ML inject 33 units SQ three times daily with meals. -Novolin R 100 units/ml was documented as not recorded from 10/01/22 before breakfast to 10/02/22 before dinner, and 10/05/22 before lunch. -There were no comments related to why Novolin R 100 units/ml, inject 33 units SQ three times daily was not recorded. p. Review of Resident #2's physician's orders dated 11/10/22 revealed there was an order for Tresiba FlexPen (a long-acting insulin used to treat high blood sugar levels) 200 units, inject 60 units subcutaneously (SQ) daily. Review of Resident #2's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Tresiba 200 units, inject 60 units subcutaneously daily at 9:00am. -Tresiba was documented as not recorded on 11/19/22 and 11/23/22. -There were no comments related to why Tresiba 200 units, inject 60 units SQ daily was not recorded. Refer to interview with the Corporate Nurse on 12/07/22 at 10:45am. Refer to interview with a medication aide (MA) on 12/08/22 at 3:00pm. Refer to interview with a second MA on 12/09/22 at 11:43am. Refer to interview with the ADON on 12/09/22 at 3:15pm. Refer to interview with the Administrator on	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 57 12/09/22 at 3:35pm. 2. Review of Resident #1's FL2 dated 06/14/22 revealed a diagnosis of chronic atrial fibrillation, urinary tract infection, generalized muscle weakness, right should joint subluxation. a. Review of Resident #1's current FL2 dated 06/14/22 revealed there was an order for aripiprazole (used to treat depression) 10mg one tablet daily. Review of Resident #1's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for aripiprazole 10mg one tablet daily scheduled at 8:00am. -The aripiprazole was documented as not recorded on 10/01/22 to 10/03/22. -There were no comments related to why the aripiprazole 10mg one tablet daily was not recorded. Review of Resident #1's November 2022 eMAR revealed: -There was an entry for aripiprazole 10mg one tablet daily scheduled at 8:00am. -The aripiprazole was documented as not recorded on 11/08/22, 11/19/22 and 11/23/22. -There were no comments related to why the aripiprazole 10mg one tablet daily was not recorded. b. Review of Resident #1's current FL2 dated 06/14/22 revealed there was an order for atorvastatin (used to treat coronary artery disease) 40mg one tablet at bedtime. Review of Resident #1's October 2022 electronic Medication Administration Record (eMAR)	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 58 revealed: -There was an entry for atorvastatin 40mg one tablet daily at bedtime. -Atorvastatin was documented as not recorded on 10/01/22 and 10/02/22. -There were no comments related to why the atorvastatin 40mg one tablet daily was not recorded. Review of Resident #1's November 2022 eMAR revealed: -There was an entry for atorvastatin 40mg one tablet daily at bedtime. -Atorvastatin was documented as not recorded on 11/07/22 to 11/08/22 and 11/18/22 to 11/19/22. -There were no comments related to why the atorvastatin 40mg one tablet daily was not recorded. c. Review of Resident #1's current FL2 dated 06/14/22 revealed there was an order for doxazosin (used to treat hypertension) 2mg one table at bedtime. Review of Resident #1's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for doxazosin 2mg one tablet at bedtime. - Doxazosin was documented as not recorded on 10/01/22 and 10/02/22. -There were no comments related to why the doxazosin 2mg one tablet at bedtime was not recorded. Review of Resident #1's November 2022 eMAR revealed: -There was an entry for doxazosin 2mg one tablet at bedtime. - Doxazosin was documented as not recorded on	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 59 11/07/22 to 11/08/22 and 11/18/22 to 11/19/22. -There were no comments related to why the doxazosin 2mg one tablet at bedtime was not recorded. d. Review of Resident #1's current FL2 dated 06/14/22 revealed there was an order for Eliquis (used to treat atrial fibrillation) 5mg one tablet twice daily at 8:00am and 8:00pm. Review of Resident #1's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Eliquis 5mg one tablet twice daily at 8:00am and 8:00pm. -Eliquis was documented as not recorded on 10/01/22 to 10/03/22 at 8:00am. -Eliquis was documented as not recorded on 10/01/22 and 10/02/22 at 8:00pm. -There were no comments related to why the Eliquis 5mg one tablet twice daily was not recorded. Review of Resident #1's November 2022 eMAR revealed: -There was an entry for Eliquis 5mg one tablet twice daily at 8:00am and 8:00pm. -Eliquis was documented as not recorded on 11/03/22, 11/08/22 and 11/19/22 at 8:00am. -Eliquis was documented as not recorded on 11/07/22 to 11/08/22 and 11/18/22 to 11/19/22 at 8:00pm. -There were no comments related to why the Eliquis 5mg one tablet twice daily was not recorded. e. Review of Resident #1's current FL2 dated 06/14/22 revealed there was an order for escitalopram (used to treat depression) 20mg one tablet daily.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 60 Review of Resident #1's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for escitalopram 20mg one tablet daily. -Escitalopram was documented as not recorded on 10/01/22 to 10/03/22. -There were no comments related to why the escitalopram 20mg one tablet daily was not recorded. Review of Resident #1's November 2022 eMAR revealed: -There was an entry for escitalopram 20mg one tablet daily. -Escitalopram was documented as not recorded on 11/03/22, 11/08/22 and 11/19/22. -There were no comments related to why the escitalopram 20mg one tablet daily was not recorded. f. Review of Resident #1's current FL2 dated 06/14/22 revealed there was an order for latanoprost (used to treat glaucoma) 0.005% one drop each eye at bedtime. Review of Resident #1's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for latanoprost 0.005% one drop each eye at bedtime. -Latanoprost was documented as not recorded on 10/01/22 to 10/03/22. -There were no comments related to why the latanoprost 0.005% one drop each eye at bedtime was not recorded. Review of Resident #1's November 2022 eMAR revealed:	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 61 -There was an entry for latanoprost 0.005% one drop each eye at bedtime. -Latanoprost was documented as not recorded on 11/07/22 to 11/08/22 and 11/18/22 to 11/19/22. -There were no comments related to why the latanoprost 0.005% one drop each eye at bedtime was not recorded. g. Review of Resident #1's current FL2 dated 06/14/22 revealed there was an order for metoprolol (used to treat heart failure) 25mg one tablet daily. Review of Resident #1's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was and entry for metoprolol 25mg one tablet daily. -Metoprolol was documented as not recorded on 10/01/22 to 10/03/22. -There were no comments related to why the metoprolol 25mg one tablet daily was not recorded. Review of Resident #1's November 2022 eMAR revealed: -There was an entry for metoprolol 25mg one tablet daily. -Metoprolol was documented as not recorded on 11/08/22, 11/19/22 and 11/3/22. -There were no comments related to why the metoprolol 25mg one tablet daily was not recorded. Refer to interview with the Corporate Nurse on 12/07/22 at 10:45am. Refer to interview with a medication aide (MA) on 12/08/22 at 3:00pm.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 62 Refer to interview with a second medication aide (MA) on 12/09/22 at 11:43am. Refer to interview with the ADON on 12/09/22 at 3:15pm. Refer to interview with the Administrator on 12/09/22 at 3:35pm. 3. Review of Resident #5's current FL2 dated 07/12/22 revealed diagnoses included fracture of upper and lower end fibula, difficulty walking, muscle weakness and lack of coordination. a. Review of Resident #5's current FL2 dated 07/12/22 revealed there was an order for aspirin (used to reduce heart attack) 81mg one tablet daily. Review of Resident #5's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for aspirin 81mg one tablet daily. -Aspirin was documented as not recorded on 10/01/22 to 10/03/22. -There were no comments related to why the aspirin 81mg one tablet daily was not recorded. Review of Resident #5's November 2022 eMAR revealed: -There was an entry for aspirin 81mg one tablet daily. -Aspirin was documented as not recorded on 10/08/22, 10/19/22 and 10/23/22. -There were no comments related to why the aspirin 81mg one tablet daily was not recorded. b. Review of Resident #5's current FL2 dated 07/12/22 revealed there was an order for	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 63 baclofen (used to relax muscles) 10mg one tablet daily. Review of Resident #5's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for baclofen 10mg one tablet daily. -Baclofen was documented as not recorded on 10/01/22 to 10/03/22. -There were no comments related to why the baclofen 10mg one tablet daily was not recorded. Review of Resident #5's physician's order dated 11/10/22 revealed there was an order for baclofen 10mg one tablet twice daily. Review of Resident #5's November 2022 eMAR revealed: -There was an entry for baclofen 10mg one tablet daily from 11/01/22 to 11/10/22. -There was an entry for baclofen 10mg one tablet twice daily from 11/10/22 to 11/30/22. -Baclofen was documented as not recorded on 11/08/22, 11/19/22, 11/23/22 at 8:00am and 11/18/22, 11/19/22 at 8:00pm. -There were no comments related to why the baclofen 10mg one tablet daily was not recorded. c. Review of Resident #5's current FL2 dated 07/12/22 revealed there was an order for carbidopa/levodopa (used to treat Parkinson's disease) 25-100mg one and a half tablet three times daily. Review of Resident #5's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for carbidopa/levodopa 25-100mg one and a half tablet three times daily	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 64	D 367		

at 8:00am, 2:00pm and 8:00pm.
-Carbidopa/levodopa was documented as not recorded on 10/01/22 8:00am, 2:00pm and 8:00pm, 10/02/22 8:00am, 2:00pm and 8:00pm, 10/10/22 2:00pm and 10/26/22 2:00pm.
-There were no comments related to why the carbidopa/levodopa 25-100mg one and a half tablet three times daily was not recorded.

Review of Resident #5's November 2022 eMAR revealed:
-There was an entry for carbidopa/levodopa 25-100mg one and a half tablet three times daily at 8:00am, 2:00pm and 8:00pm.
-Carbidopa/levodopa was documented as not recorded on 11/07/22 8:00pm, 11/08/22 8:00am, 2:00pm and 8:00pm, 11/12/22 2:00pm, 11/18/22 8:00pm, 11/19/22 8:00am, 8:00pm and 11/23/22 8:00am.
-There were no comments related to why the carbidopa/levodopa 25-100mg one and a half tablet three times daily was not recorded.

d. Review of Resident #5's current FL2 dated 07/12/22 revealed there was an order for diltiazem (used to treat high blood pressure) 300mg one table every morning.

Review of Resident #5's October 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for diltiazem 300mg one tablet every morning.
-Diltiazem was documented as not recorded on 10/01/22 to 10/03/22.
-There were no comments related to why the diltiazem 300mg one tablet every morning was not recorded.

Review of Resident #5's November 2022 eMAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 CARMEL ROAD CHARLOTTE, NC 28226

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D 367	Continued From page 65 revealed: -There was an entry for diltiazem 300mg one tablet every morning. -Diltiazem was documented as not recorded on 11/08/22, 11/19/22 and 11/23/22. -There were no comments related to why the diltiazem 300mg one tablet every morning was not recorded. e. Review of Resident #5's current FL2 dated 07/12/22 revealed there was an order for docusate sodium (to treat constipation) 100mg one capsule once daily. Review of Resident #5's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for docusate sodium 100mg one capsule daily. -Docusate sodium was documented as not recorded on 10/01/22 to 10/03/22. -There were no comments related to why the docusate sodium 100mg one capsule daily was not recorded. Review of Resident #5's November 2022 eMAR revealed: -There was an entry for docusate sodium 100mg one capsule daily. -Docusate sodium was documented as not recorded on 11/08/22, 11/19/22 and 11/23/22. -There were no comments related to why the docusate sodium 100mg one capsule daily was not recorded. f. Review of Resident #5's current FL2 dated 07/12/22 revealed there was an order for escitalopram (to treat depression) 10mg one tablet daily.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 66 Review of Resident #5's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for escitalopram 10mg one tablet daily. -Escitalopram was documented as not recorded on 10/01/22 to 10/03/22. -There were no comments related to why the escitalopram 10mg one tablet daily was not recorded. Review of Resident #5's November 2022 eMAR revealed: -There was an entry for escitalopram 10mg one tablet daily. -Escitalopram was documented as not recorded on 11/08/22, 11/19/22 and 11/23/22. -There were no comments related to why the escitalopram 10mg one tablet daily was not recorded. g. Review of Resident #5's current FL2 dated 07/12/22 revealed there was an order for melatonin (used for insomnia) 3mg one tablet at bedtime. Review of Resident #5's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for melatonin 3mg one tablet at bedtime. -Melatonin was documented as not recorded on 10/01/22 and 10/02/22. -There were no comments related to why the melatonin 3mg one tablet at bedtime was not recorded. Review of Resident #5's November 2022 eMAR revealed: -There was an entry for melatonin 3mg one tablet	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 67	D 367		

at bedtime.
-Melatonin was documented as not recorded on 11/07/22, 11/08/22, 11/18/22 and 11/19/22.
-There were no comments related to why the melatonin 3mg one tablet at bedtime was not recorded.

h. Review of Resident #5's current FL2 dated 07/12/22 revealed there was an order for oxybutynin (to treat overactive bladder) 5mg one tablet daily.

Review of Resident #5's October 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for oxybutynin 5mg one tablet daily.
-Oxybutynin was documented as not recorded on 10/01/22 to 10/03/22.
-There were no comments related to why the oxybutynin 5mg one tablet daily was not recorded.

Review of Resident #5's November 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for oxybutynin 5mg one tablet daily.
-Oxybutynin was documented as not recorded on 11/08/22, 11/19/22 and 11/23/22.
-There were no comments related to why the oxybutynin 5mg one tablet daily was not recorded.

i. Review of Resident #5's current FL2 dated 07/12/22 revealed there was an order for pantoprazole (used to treat acid reflux) 40mg one tablet daily.

Review of Resident #5's October 2022 electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 68	D 367		

Medication Administration Record (eMAR) revealed:
-There was an entry for pantoprazole 40mg one tablet daily.
-Pantoprazole was documented as not recorded on 10/01/22 to 10/03/22.
-There were no comments related to why the pantoprazole 40mg one tablet daily was not recorded.

Review of Resident #5's November 2022 eMAR revealed:
-There was an entry for pantoprazole 40 mg one tablet daily.
-Pantoprazole was documented as not recorded on 11/08/22.
-There were no comments related to why the pantoprazole 40mg one tablet daily was not recorded.

j. Review of Resident #5's current FL2 dated 07/12/22 revealed there was an order for polyethylene glycol (used to treat constipation) 3350, 17gm mixed in 4-8 ounces (oz) of liquid once daily.

Review of Resident #5's October 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for polyethylene glycol 3350, 17gm mixed in 4-8 oz of liquid daily.
-Polyethylene glycol 3350 was documented as not recorded on 10/01/22 to 10/03/22.
-There were no comments related to why the polyethylene glycol 3350, 17gm mixed in 4-8 oz of liquid daily was not recorded.

Review of Resident #5's November 2022 eMAR revealed:
-There was an entry for polyethylene glycol 3350,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 69 17gm mixed in 4-8 oz of liquid daily. -Polyethylene glycol 3350 was documented as not recorded on 11/08/22, 11/19/22 and 11/23/22. -There were no comments related to why the polyethylene glycol 3350, 17gm mixed in 4-8 oz of liquid daily was not recorded. k. Review of Resident #5's current FL2 dated 07/12/22 revealed there was an order for ropinirole (used to treat symptoms of Parkinson's disease) 0.25mg one tablet three times daily. Review of Resident #5's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for ropinirole 0.25mg one tablet three times daily at 8:00am, 2:00pm and 8:00pm. -Ropinirole was documented as not recorded on 10/01/22 at 8:00am, 2:00pm and 8:00pm, 10/02/22 at 8:00am, 2:00pm and 8:00pm, 10/03/22 22 at 8:00am, 10/10/22 at 2:00pm and 10/26/22 at 2:00pm. -There were no comments related to why the ropinirole 0.25mg one tablet three times daily was not recorded. Review of Resident #5's November 2022 eMAR revealed: -There was an entry for ropinirole 0.25mg one tablet three times daily at 8:00am, 2:00pm and 8:00pm. -Ropinirole was documented as not recorded on 11/07/22 at 8:00pm, 11/08/22 at 8:00am, 2:00pm and 8:00pm, 11/18/22 at 8:00pm, 11/19/22 at 8:00am and 8:00pm, and 11/23/22 at 8:00am. -There were no comments related to why the ropinirole 0.25mg one tablet three times daily was not recorded.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 70	D 367		

I. Review of Resident #5's current FL2 dated 07/12/22 revealed there was an order for senna-time (used to treat constipation) 8.6mg one tablet every night at bedtime.

Review of Resident #5's October 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for senna-time 8.6mg one tablet every night at bedtime.
-Senna-time was documented as not recorded on 10/01/22 to 10/03/22.
-There were no comments related to why the senna-time 8.6mg one tablet every night at bedtime was not recorded.

Review of Resident #5's November 2022 eMAR revealed:
-There was an entry for senna-time 8.6mg one tablet every night at bedtime.
-There were no comments related to why the senna-time 8.6mg one tablet every night at bedtime was not recorded.
-Senna-time was documented as not recorded on 11/08/22, 11/19/22 and 11/23/22.

Refer to interview with the Corporate Nurse on 12/07/22 at 10:45am.

Refer to interview with a medication aide (MA) on 12/08/22 at 3:00pm.

Refer to interview with a second MA on 12/09/22 at 11:43am.

Refer to interview with the Assistant DON on 12/09/22 at 3:15pm.

Refer to interview with the Administrator on 12/09/22 at 3:35pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 71 4. Review of Resident #7's current FL2 dated 10/24/22 revealed: -Diagnoses included type 2 diabetes. -An order to check finger stick blood sugar (FSBS) three times a day. -An order to administer Novolog 100 units/ml insulin (a rapid-acting insulin used to control elevated blood sugar), per the sliding scale: FSBS 0-100= 0 units; FSBS 101-150= 2 units; FSBS 151- 250= 4 units; FSBS 251-400= 8 units; FSBS 401-450= 10 units; if blood sugar is greater than 450 notify the physician. Review of Resident #7's physician's orders dated 10/28/22 revealed: -There was an order to check FSBS three times daily. -An order to administer Novolog 100 units/ml insulin (a rapid-acting insulin used to control elevated blood sugar), per the sliding scale: FSBS 0-100= 0 units; FSBS 101-150= 2 units; FSBS 151- 250= 4 units; FSBS 251-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if blood sugar is greater than 450 notify the physician. Review of Resident #7's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was no entry to check FSBS three times daily. -There was no entry to administer Novolog 100 units/ml insulin (a rapid-acting insulin used to control elevated blood sugar), per the sliding scale: FSBS 0-100= 0 units; FSBS 101-150= 2 units; FSBS 151- 250= 4 units; FSBS 251-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if blood sugar is greater than 450 notify the physician.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 72 Review of Resident #7's November 2022 eMAR revealed: -There was an entry to check FSBS three times daily. -There was an entry to administer Novolog 100 units/ml insulin (a rapid-acting insulin used to control elevated blood sugar), per the sliding scale: FSBS 0-100= 0 units; FSBS 101-150= 2 units; FSBS 151-250= 4 units; FSBS 251-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if blood sugar is greater than 450 notify the physician -The entry for Novolog was documented as not recorded on 11/07/22 at 8:00pm, 11/08/22 at 8:00am, 12:00pm, 8:00pm, 11/18/22 at 8:00pm, 11/19/22 at 8:00pm, and 11/29/22 at 8:00pm. -There were no comments related to why the Novolog insulin 100 units/ml per the sliding scale was not recorded. Refer to interview with the Corporate Nurse on 12/07/22 at 10:45am. Refer to interview with a medication aide (MA) on 12/08/22 at 3:00pm. Refer to interview with a second MA on 12/09/22 at 11:43am. Refer to interview with the ADON on 12/09/22 at 3:15pm. Refer to interview with the Administrator on 12/09/22 at 3:35pm. Interview with the Corporate Nurse on 12/07/22 at 10:45am revealed: -The dashes on the eMAR indicated the computer system did not work at the time of the	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 73	D 367		

medication pass.
-The MAs were responsible for notifying the pharmacy when the computer system was down and received paper MARs from the pharmacy to complete medication administration and documentation.
-The MAs were responsible for documenting on the paper MAR during the computer down time and if the computer came back up during their shift the MA was responsible for documentation of a late note in the eMAR and place the paper MARs in the nursing office for review.
-The ADON and DON were responsible for reviewing the paper MARs and recording in the eMAR the undocumented medications that were administered during the down time.
-The MAs were responsible for weekly medication cart audits, which would ensure the medications, eMAR, and physician orders all matched.
-The ADON and DON were responsible for weekly medication cart audits, which would ensure the medications, eMAR, and physician orders all matched.
-She did not know the medication cart audits were not completed.

Interview with MA on 12/08/22 at 3:00pm revealed:
-The facility's internet was down at times and they were unable to document medication administration on the eMAR.
-When the internet was down, she called the pharmacy and requested paper MARs to document on.
-She did recall giving resident's their medications when the eMAR system was down but does not recall dates.
-She did recall manually documenting on the paper MAR.
-She stated she did place the paper MARs in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060168	A. BUILDING: _____ B. WING _____	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES ON CARMEL SENIOR LIVING	5820 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 367	Continued From page 74 shredder bin after each shift. -She did not recall anyone telling her to keep the residents' paper MAR's. Interview with a second MA on 12/09/22 at 11:43am revealed: -She could not document medications as administered from October to December 2022 several times due to the internet being down. -When the internet was down, she called the pharmacy and received paper MARs to document administration of medications. -Once the medications were documented as administered on the paper MARs, she left them for the DON to document in the eMAR system once the internet was back up. -The MAs were responsible for the medications in the medication cart matching the eMAR before they could be administered. -The MAs, DON and the ADON were responsible for weekly medication cart audits where they would compare the medications on the cart to the eMAR and physician orders for accuracy. -She did not complete any medication cart audits at all. Interview with the ADON on 12/09/22 at 3:15pm revealed: -The MAs were responsible for administering medications according to the physician's order. -The MAs were responsible for using a paper MAR supplied by the pharmacy when the computer system could not be accessed. -She and the DON were responsible for entering the medications and information into the eMAR system using the paper MARs once the eMAR system was back up. -She and the DON were responsible for reviewing the eMAR system during the medication cart audits, periodically for completion.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 75 -In September 2022, the facility switched over to a new eMAR system. -She was unaware of issues with completion of the medications in the new eMAR system. -She did not complete any of the audits of the eMARs, paper MARs or medication variance reports. Interview with the Administrator on 12/09/22 at 3:35pm revealed: -The MAs were responsible for administering medications according to the physician's order. -The MAs were responsible for using a paper MAR supplied by the pharmacy when the computer system could not be accessed. -The ADON and the DON were responsible for entering the medications and information into the eMAR system using the paper MARs once the eMAR system was back up. -The ADON and the DON were responsible for reviewing the eMAR system during the medication cart audits, periodically for completion. -In September 2022, the facility switched over to a new eMAR system. -She did not complete any audits after the ADON or DON, or follow up on any of the clinical concerns because she was not clinical and that was the responsibility of the ADON and DON. -She was not aware of any of the issues with medication administration records.	D 367		