STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060161	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS IN HIGHLAND CREEK	6101 CLARKE CREEK PARKWAY CHARLOTTE, NC 28269

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey on 11/19//2024 and 11/20/2024.	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 ensure referral and follow-up to meet the routine healthcare needs for 2 of 5 sampled residents related to a psychology referral (#3) and orders for QuantiFERON (QFT) Gold tuberculin (TB) testing (#3 and #4). The findings are: 1. Review of Resident #3's current FL2 dated 04/02/24 revealed diagnoses included cerebral infarct (stroke) and cognitive communication deficit. a. Review of Resident #3's Primary Care Provider's (PCP) order dated 09/17/24 revealed the resident was to be referred to the in-house psychologist. Review of Resident #3's record revealed there was no documentation the resident was seen by the psychologist. Interview with the Assistant Health and Wellness Director (AHWD) on 11/20/24 at 1:42pm revealed:	D 273		

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D 273	Continued From page 1	D 273		

-A medication aide (MA) was working with Resident #3's PCP on 09/17/24 when the psychology referral order was written.
-The MA was responsible for faxing the psychology referral for Resident #3 to the psychologist.
-The AHWD found Resident #3's psychology referral order in her chart on 10/10/24.
-On 10/10/24 she did not see a fax confirmation sheet indicating the MA had faxed the referral.
-On 10/10/24 she texted the psychologist to make him aware Resident #3 was to be seen.
-She thought she also faxed the referral to his office on 10/10/24 but she could not find a fax confirmation sheet.

Interview with the Health and Wellness Director (HWD) on 11/20/24 at 2:24pm revealed.
-The AHWD was responsible for notifying any referral providers to ensure the referral was completed.
-The process was to keep fax confirmations for documentation of the referral.

Interview with the Regional Director of Health and Wellness on 11/20/24 at 3:02pm revealed:
-The staff member who received the referral order should process the referral.
-Both the AHWD and the HWD were responsible for ensuring referrals were followed up on but ultimately it was the HWD's responsibility.

b. Review of Resident #3's PCP order dated 08/27/24 revealed the resident was to have a QuantiFERON (QFT) Gold test to assess for TB.

Review of Resident #3's record revealed there were no documented results of a QFT TB test.

Refer to the interview with the AHWD on 11/20/24

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D 273	Continued From page 2 at 2:11pm. Refer to the interview with the HWD on 11/20/24 at 2:24pm. Refer to the interview with the Regional Director of Health and Wellness on 11/20/24 at 3:02pm. 2. Review of Resident #4's current FL2 dated 08/14/24 revealed diagnoses included diabetes, hypertension and osteoporosis. Review of Resident #4's PCP order dated 08/27/24 revealed the resident was to have a QFT Gold test to assess for TB. Review of Resident #4's record revealed there were no documented results of a QFT TB test. Refer to the interview with the AHWD on 11/20/24 at 2:11pm. Refer to the interview with the HWD on 11/20/24 at 2:24pm. Refer to the interview with the Regional Director of Health and Wellness on 11/20/24 at 3:02pm. _____ Interview with the AHWD on 11/20/24 at 2:11pm revealed: -The previous HWD was responsible for ensuring resident TB tests and TB orders were completed. -She was not aware there was no follow-up on Resident #3 and Resident #4's QFT Gold TB test orders. Interview with the HWD on 11/20/24 at 2:24pm revealed: -The HWD and the AHWD were responsible for ensuring residents had a second step TB test or	D 273		

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D 273	Continued From page 3 QFT Gold TB test completed after admission to the facility when needed. -He started working at the facility the beginning of October 2024 and was unsure if any chart audits were in place to ensure TB tests were completed. Interview with the Regional Director of Health and Wellness on 11/20/24 at 3:02pm revealed: -The AHWD and HWD were responsible for ensuring all residents had a two-step TB test or QFT Gold TB test. -She completed audits at the facility at least annually.	D 273		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the staff person who administered medications observed the resident actually take the medications prior to the administration of another resident's medication for 1 of 5 sampled residents (#1). The findings are: Review of Resident #1's current FL2 dated	D 366		

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D 366	Continued From page 4 11/12/24 revealed diagnoses included type II diabetes mellitus, dementia, Parkinson's disease, chronic obstructive pulmonary disease, chronic pain syndrome, and high blood pressure. Review of Resident #1's Resident Register revealed a facility admission date of 06/12/24. Observation of Resident #1's room on 11/19/24 at 9:35 am revealed: -There was no medication aide (MA) in the resident's room. -There was a paper medication cup full of more than 10 unknown pills and capsules on the bedside table. -The medications were not labeled with resident or medication identifiers. -There was a tube of topical cream used for skin irritation on her bedside table. -The tube was not labeled with resident identifiers. -There was an inhaler used to prevent and treat difficulty breathing, wheezing or shortness of breath -The inhaler was not labeled with resident identifiers. Interview with Resident #1 on 11/19/24 at 9:35 am revealed: -The cup of medications was given to her earlier in the morning by the MA. -She was unsure of the exact time the medications were left with her in her room. -She was in the process of taking the medications. -She did not usually keep medications on her bedside table. A second interview with Resident #1 on 11/19/24 at 1:24 pm revealed:	D 366		

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D 366	Continued From page 5	D 366		

-The resident did not know when the tube of cream was placed on her bedside table.
-She used the cream as needed for itching of her hands.
-She used the cream "only every two months or so".
-She could not recall when she last used the cream.
-She believed the cream was usually given to her by the MA.
-She did not know when the inhaler was placed on her bedside table.
-She used the inhaler when she was short of breath. She used the inhaler "about once a day."
-She believed the MA brought her the inhaler when needed.

Interview with the MA on 11/19/24 at 1:42 pm revealed:
-She gave Resident #1 her medications that morning.
-She said Resident #1 "moves around the room while I'm trying to give them so I might have put them on her table."
-She usually waited until Resident#1 took her medications before leaving the room and knew the process was to watch the resident take their medications before leaving the room.
-She did not recall if the resident took all her medications that morning while she (the MA) was in the room.
-If she saw medications in the room, she would remove them and notify her supervisor.

Interview with the Health and Wellness Director (HWD) on 11/20/24 at 3 pm revealed:
-He was not aware any medications were left at Resident #1's bedside.
-His expectation was that medications were administered correctly.

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D 366	Continued From page 6 -To ensure medications were administered correctly, the Regional HWD or Regional Clinical Supervisor provided medication training. -The MA was required to review the facility's medication policy during training and as needed. Interview with the Regional HWD on 11/20/24 at 3:04 pm revealed: -Her expectation was that medications would have been administered correctly by the MA. -Her expectation was that the HWD and the AHWD observed the MA "at intervals" to ensure correct medication administration. -Medications should never be left at bedside by the MA.	D 366		
D 412	10A NCAC 13F .1010 (e) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to provide pharmaceutical services that ensured accurate records of the receipt of medications were maintained in the facility for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL2 dated	D 412		

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D 412	Continued From page 7 04/02/24 revealed diagnoses included cerebral infarction (stroke), heart failure, atrial fibrillation, polyneuropathy, and hyperlipidemia. Observation of medications on hand for Resident #3 on 11/20/24 at 11:39am revealed: -The medications were packaged in bubble packs. -Handwritten on the front of the medication bubble packs was the resident's name, room number, medication name, strength, and directions for administration. -There was no dispensing pharmacy indicated on the bubble packs. -On the back of the bubble pack, there was a pre-printed box containing fields "filled by" and "received by". -The "filled by" field contained handwritten initials. -The "received by" field was blank. Interview with the Assistant Health and Wellness Director (AHWD) for the Special Care Unit (SCU) on 10/20/24 at 11:39 revealed: -Resident #3's medications were not provided by the facility's contracted pharmacy. -Resident #3's family member had her medications packaged in bubble packs and brought them to the facility. Telephone interview with Resident #3's family member on 10/20/24 at 12:05pm revealed: -She had Resident #3's medications packaged in bubble packs and brought a month's supply to the facility each month. -When she brought Resident #3's medications to the facility, she gave them to the medication aide (MA) on duty. Interview with a MA on 11/20/24 at 1:55pm revealed:	D 412		

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D 412	Continued From page 8 -When Resident #3's family member brought in her medications, she placed them in the medication cart. -There was no documentation of what medications or quantities were received for Resident #3. -When medications were delivered from a pharmacy, she was required to sign for them. Interview with the AHWD on 11/20/24 at 1:42pm revealed there was no documentation of medications received for Resident #3. Interview with the Regional Director of Health and Wellness on 11/20/24 at 3:02pm revealed: -She thought Resident #3's medications may not have been tracked because the family member had them prepackaged and dropped them off at the facility. -She expected staff members to document any time medications were brought to the facility by a family member.	D 412		