STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060019	A. BUILDING: _____ B. WING _____	R 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF CHARLOTTE	6000 PARK SOUTH DRIVE CHARLOTTE, NC 28210

(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 a follow-up survey on October 22, 2024 through October 24, 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 with a physician for 2 of 7 sampled residents, who had blood pressures with parameters and sliding scale insulin (SSI) orders and missed the SSI for 9 days (Resident #1) and a resident who had a physical therapy (PT) and occupational therapy (OT) (Resident #4). The findings are: 1. Review of Resident #4's current FL-2 dated 08/07/24 revealed: -Diagnoses included moderate dementia with behavioral disturbance, Type 2 diabetes mellitus without complications, hypothyroidism, history of abdominal cancer. -Resident #4's level of care was Special Care Unit (SCU). Review of Resident #4's Resident Register revealed resident was admitted to the facility on 08/07/24. Review of Resident #4's Progress Notes dated 09/26/24 revealed:	D 273	please see attached Plan of Correction	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 11/27/24

Reviewed and Acknowledged by MH on 12/02/2024

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D 273	Continued From page 1 -Resident #4 had unwitnessed fall with no injuries. -The responsible party and Primary Care Provider (PCP) were notified on 09/26/24. - Care Plan was reviewed with no updates were made. Review of Resident #4's rehabilitation screening form dated 10/02/24 revealed referrals for PT, OT, and Speech Therapy (ST) were made due to a recent fall for an evaluation and treatment. Review of Resident #4's records revealed there was no documentation of follow up referral or evaluation was completed for PT, OT, and ST. Interview with the Physical Therapist Assistant (PTA) on 10/23/24 at 1:37pm revealed: -There was no evaluation completed on Resident #4. -The company was not certified to bill the resident's medical insurance. Telephone Interview with Resident #4's Responsible Party (RP) on 10/24/24 at 9:53am revealed: -Resident #4 moved to the facility a couple of months ago. -He was ambulatory and impulsive. -Resident #4 often tried to walk without his walker. -She was made aware of the fall on 09/26/24. Interview with Special Care Unit Coordinator (SCC) on 10/24/24 at 11:43am revealed: -When referrals for services was recommended, she completed the preliminary review. - If a resident was not appropriate for therapy services or the contract agency could not bill the resident's Medicare provider, the PTA or the	D 273		

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D 273	Continued From page 2 Senior Resident Care Director (SRCD) would be responsible to complete a referral to a Home Health (HH) agency. Telephone Interview with Resident #4's Primary Care Provider (PCP) on 10/23/24 at 10:57am revealed: -She received an incident report in reference to the fall on 09/26/24 on 10/02/24. -The incident report was initially sent to another provider in error. -She followed Resident #4 and helped manage his care. -She was not aware of a referral to HH for the PT, OT and ST services until today 10/23/24. -When she received a referral for HH services, she would forward the referral directly to a HH agency with any documentation needed for services to start. -She received a referral for Resident #4 today 10/23/24. Interview with the Senior Resident Care Director (SRCD) on 10/24/24 at 2:35pm revealed: -When a resident is recommended for PT, OT and ST they would be discussed in the daily standup meeting with participation from the PTA. -Due to Resident #4's recent fall a screening referral was triggered. -A recommendation was made for PT, OT and ST to evaluate Resident #4. -The evaluation was made, and the screening form was completed. - She did not know if a referral had been completed. -Resident #4's record had no documentation the referral was forwarded to HH. -There was no written policy or protocol to ensure that referrals were completed as recommended. -Resident #4's referral was completed and given	D 273		

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D 273	Continued From page 3 to the contract therapy provider today 10/23/24. Interview with the Administrator on 10/24/24 at 11:44 am revealed: -He did not know Resident #4 did not get therapy services as recommended on 10/02/24. -When referrals were sent to the in-house contracted therapy provider and they could not provide services, the referral was to be forwarded to a third party provider or the SRCD could initiate a referral. -He expected the SRCD to ensure all referrals were submitted, initiated, and documented in the resident's record. -He was unaware of any written policy or process to ensure referrals were completed with services put in place as recommended. 2. Review of Resident #1's current FL-2 dated 08/13/24 revealed diagnoses included diabetes mellitus, chronic kidney disease stage 3, metabolic encephalopathy and hypertension. Review of Resident #1's Resident Register revealed resident was admitted to the facility on 08/07/24. a. Review of the facility's Diabetic Quick Reference Guide dated July 2024 revealed: -SSI orders required high and low parameters for notification to the physician. -Parameters included a finger stick blood sugar (FSBS) <70 (hypoglycemia) and >400 (hyperglycemia). Review of Resident #1`'s hospital discharge summary dated 09/27/24 revealed: -A discharge diagnosis of pulmonary embolis (PE), COVID-19 virus infection, primary	D 273		

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D 273	Continued From page 4 hypertension, chronic obstructive disease (COPD and type 2 diabetes without complication. -There was an order to check a FSBS before meals and at bedtime. -There was an order for Fiasp insulin U-100 (a fast-acting insulin to treat high blood sugars), check FSBS before each meal and at bedtime and inject per SSI: FSBS: 151-160= 2 unit, 161-240= 4 units, 241-300= 6 units, 301-350= 8 units, 351-400= 10 units and FSBS > 400= 12 units and notify physician. Review of Resident #1's signed physician order dated 10/03/24 revealed: -An order for Fiasp insulin U-100, check FSBS in the AM prior to breakfast and give 5 units if FSBS is > 150. -An order for Fiasp insulin U-100, check FSBS in the PM prior to supper and give 8 units if FSBS is > 150. -Call physician if FSBS is <60 or >250. Review of Resident #1's September 2024 electronic Medication Administration Record (eMAR) for 09/27/24 to 09/30/2024 revealed: -There was not an entry for Fiasp insulin U-100, check FSBS before each meal and at bedtime and inject per SSI: FSBS: 151-160= 2 unit, 161-240= 4 units, 241-300= 6 units, 301-350= 8 units, 351-400= 10 units and FSBS > 400= 12 units and notify physician. -On 09/27/24 to 09/30/24, there was no documentation the FSBS was obtained at 6:00am, 11:00am, 4:00pm and 8:00pm. -On 09/27/24 to 09/30/24, there was no documentation the Fiasp insulin was administered at at 6:00am, 11:00am, 4:00pm and 8:00pm. -Resident #1's FSBS was not documented as obtained for 16 out of 16 opportunities.	D 273		

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D 273	Continued From page 5 Review of Resident #1's October 2024 electronic Medication Administration Record (eMAR) for 10/01/24 to 10/03/2024 revealed: -There was not an entry for Fiasp insulin U-100, check FSBS before each meal and at bedtime and inject per SSI: FSBS: 151-160= 2 unit, 161-240= 4 units, 241-300= 6 units, 301-350= 8 units, 351-400= 10 units and FSBS > 400= 12 units and notify physician. -On 10/01/24 to 10/03/24, there was no documentation the FSBS was obtained at 6:00am, 11:00am, 4:00pm and 8:00pm. -On 10/01/24 to 10/03/24, there was no documentation the Fiasp insulin was administered at at 6:00am, 11:00am, 4:00pm and 8:00pm. -Resident #1's FSBS was not documented as obtained for 12 out of 12 opportunities. Interview with the Senior Resident Care Director (SRCD) on 10/23/24 at 12:30pm revealed: -She and the RCCs were responsible for faxing Resident #1's hospital discharge summary to the pharmacy and she did not know which one of them did it. -She and the RCCs were responsible for reviewing and approving those orders once the pharmacy entered them into the eMAR system and she did not know who reviewed and approved those orders. -She was not aware that Resident #1's order for Fiasp insulin U-100 (a fast-acting insulin to treat high blood sugars), check FSBS before each meal and at bedtime and inject per SSI: FSBS: 151-160= 2 unit, 161-240= 4 units, 241-300= 6 units, 301-350= 8 units, 351-400= 10 units and FSBS > 400= 12 units and notify physician was not on the eMAR because she did not perform an audit to check the paper eMARs with the	D 273		

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D 273	Continued From page 6	D 273		

computer eMAR because that was not apart of their audits.
-When an issue like this was found, then it would be her responsibility or the RCCs to report it to the PCP because Resident #1 did not get his SSI for about 7 days.

Interview with Resident #1's Primary Care Provider (PCP) on 10/23/24 at 1:55pm revealed:
-On 10/03/24, she saw Resident #1 for a routine visit and during the review of his record she found the 09/27/24 hospital discharge orders.
-Resident #1 was discharged from the hospital on 09/27/24 with SSI orders.
-Resident #1's hospital discharge SSI orders were different than he had at the facility before the hospitalization.
-The facility was to send her the 09/27/24 hospital discharge orders for her to review and approve to avoid issues with Resident #1's treatment plans and unnecessary changes to Resident #1's treatments for his diabetes.
-She was not sent the hospital discharge orders for review and on 10/03/24, she changed Resident #1's SSI orders.

Interview with the Administrator on 10/23/24 at 12:30pm revealed:
-He was not aware of any issues related to Resident #1's SSI orders and the PCP was not notified.
-The MAs were responsible for weekly medication cart audits where the MAs compared the medications available for administration to the computer eMAR.
-The SRCD was responsible for the same medication cart audits on a monthly basis.
-The Resident Care Coordinators (RCC) and the SRCD were responsible for at least monthly audits of resident vital sign/insulin sheets to make

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D 273	Continued From page 7 sure parameters for BPs and insulin were addressed as well as the correct SSI was administered. -After completion and review of those reports, the RCCs and the SRCD were responsible for making sure any issues were addressed with the PCP. -The SRCD was responsible for reporting to him every morning in the meeting any issues related to medication administration and PCP notification. b. Review of Resident #1's current FL-2 dated 08/13/24 revealed: -There was an order for daily blood pressure (BP) checks. -There was an order for clonidine (a medication used to treat high blood pressure) 0.2mg daily as needed (PRN) for a systolic blood pressure (SBP) > 160mmHg. Review of Resident #1's August 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check BP daily 08/19/24 at 7:00am to 08/31/24. -There were no BPs documented 08/14/24 to 08/31/24. -There was an entry for clonidine 0.2mg daily as needed for a systolic blood pressure (SBP) > 160mmHg. -There was no documentation the clonidine was administered from 08/14/24 to 08/31/24. Review of Resident #1's September 2024 eMAR revealed: -There was an entry to check BP daily 09/01/24 to 09/30/24 at 7:00am. -There was an entry for clonidine 0.2mg daily as needed for a systolic blood pressure (SBP) > 160mmHg.	D 273		

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D 273	Continued From page 8 -On 09/09/24, there was documentation the resident's BP was 176/98 and there was no documentation the clonidine was administered. -On 09/15/24, there was documentation the resident's BP was 175/91 and there was no documentation the clonidine was administered. -On 09/29/24, there was documentation the resident's BP was 171/98 and there as no documentation the clonidine was administered. Review of Resident #1's October 2024 eMAR revealed: -There was an entry to check BP daily 10/01/24 to 10/22/24 at 7:00am. -There was an entry for clonidine 0.2mg daily as needed for a systolic blood pressure (SBP) > 160mmHg. -On 10/07/24, there was documentation the resident's BP was 176/98 and there was no documentation the clonidine was administered. Review of Resident #1's medications available for administration on 10/23/24 at 10:00am revealed there was a bubble pack of clonidine 0.2mg, with a label dated 08/16/24 containing 30 tablets, to administer 1 tablet as needed for a SBP > 160 with 30 tablets left to administer. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 10/23/24 at 11:35am revealed: -There was an signed physician's order dated 08/16/24 for clonidine 0.2mg daily as needed for a systolic blood pressure (SBP) > 160mmHg. -On 08/16/24, clonidine 0.2mg, 30 tablets (a 30 day supply) was dispensed to the facility. -Clonidine was not dispensed after 08/16/24. Interview with the Senior Resident Care Director (SRCD) on 10/23/24 at 12:30pm revealed:	D 273		

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D 273	Continued From page 9 -The MAs were responsible for obtaining Resident #1's BP, administering clonidine for a SBP > 160 and following up with the PCP when the SBP was > 160 or there was an issue with the order. -She did not know the SBP parameter was not entered in the eMAR with Resident #1's BP but with his PRN clonidine, therefore if the SBP was > 160, then the MA would not have been prompted to administer the PRN clonidine. -The MA were responsible for medication cart audits where the MA compared the medication on hand to the eMAR. -She did not realize the way she taught the MAs to perform the medication cart audits did not include comparing the paper eMAR and orders to the medications on hand and the computer eMAR which would have caught the entry error for the SBP parameter /clonidine order. -She performed the medication cart audits the same way and did not catch the entry error for the SBP parameter /clonidine order. -She did not complete an audit Resident #1's vital sign sheet which contained Resident #1's BPs to make sure the clonidine was administered for a SBP > 160 and the PCP was not notified. Interview with a MA on 10/24/24 at 9:40am revealed: -She obtained Resident #1's BP when she worked but did not know there were BP parameters to give clonidine because the parameters were on the clonidine PRN order in the eMAR. -Because the BP parameters were associated with the PRN clonidine, she was not prompted to administer clonidine for the BP' with SBP > 160. -There were 4 occasions between 09/01/24 and 10/22/24 Resident #1's SBP was > 160 and should have received clonidine.	D 273		

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D 273	Continued From page 10 -She was responsible for following the eMAR to administer the medications. -She would have been responsible for notification to Resident #1's PCP for a SBP > 160 had the order been attached to the BPs not the PRN clonidine. Interview with Resident #1's Primary Care Provider (PCP) on 10/23/24 at 1:55pm revealed: -The staff were responsible for notification related to the SBP > 160, which required administration of the PRN clonidine. -She was not notified about 4 times Resident #1's SBP were > 160 and required the PRN clonidine and Resident #1 did not receive the clonidine. -She should have been notified of Resident #1's SBP > 160 so she could have adjusted the treatment for Resident #1's HTN and about the PRN clonidine not being administered. -She could have also addressed the BP parameters with the BPs/clonidine. -The parameters were set in place to help be an early indication for the increased risk of a stroke. -On 10/03/24, she saw Resident #1 for a routine visit and during the review of his record she did not see a BP documented for Resident #1 that were considered a high risk for a stroke (SBP >200 and DBP >100). Interview with the Administrator on 10/23/24 at 12:30pm revealed: -He was not aware of any issues related to Resident #1's BP parameters/clonidine and the PCP was not notified. -The MAs were responsible for weekly medication cart audits where the MAs compared the medications available for administration to the computer eMAR. -The SRCD was responsible for the same medication cart audits on a monthly basis.	D 273		

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D 273	Continued From page 11 -The Resident Care Coordinators (RCC) and the SRCD were responsible for at least monthly audits of resident vital sign/insulin sheets to make sure parameters for BPs and insulin were addressed as well as the correct SSI was administered. -After completion and review of those reports, the RCCs and the SRCD were responsible for making sure any issues were addressed with the PCP. -The SRCD was responsible for reporting to him every morning in the meeting any issues related to medication administration and PCP notification.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 sampled residents who was prescribed a rapid-acting insulin to treat high blood sugars and a medication used to treat high blood pressure (Resident #1) and failed to implement a medication time change from an evening dose to a morning dose (Resident #5). The findings are:	D 358		

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D 358	Continued From page 12 1. Review of Resident #1's current FL-2 dated 08/13/24 revealed diagnoses included diabetes mellitus, chronic kidney disease stage 3, metabolic encephalopathy and hypertension. Review of Resident #1's Resident Register revealed resident was admitted to the facility on 08/07/24. a. Review of Resident #1's current FL-2 dated 08/13/24 revealed: -There was an order for daily blood pressure (BP) checks. -There was an order for clonidine (a medication used to treat high blood pressure) 0.2mg daily as needed (PRN) for a systolic blood pressure (SBP) > 160mmHg. Review of Resident #1's August 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check BP daily 08/19/24 at 7:00am to 08/31/24. -There was no BP documented 08/14/24 to 08/31/24. -There was an entry for clonidine 0.2mg daily as needed for a systolic blood pressure (SBP) > 160mmHg. -There was no documentation the clonidine was administered. Review of Resident #1's September 2024 eMAR revealed: -There was an entry to check BP daily 09/01/24 to 09/30/24 at 7:00am. -There was an entry for clonidine 0.2mg daily as needed for a systolic blood pressure (SBP) > 160mmHg. -On 09/09/24, there was documentation the	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 13 resident's BP was 176/98 and there was no documentation the clonidine was administered. -On 09/15/24, there was documentation the resident's BP was 175/91 and there was no documentation the clonidine was administered. -On 09/29/24, there was documentation the resident's BP was 171/98 and there as no documentation the clonidine was administered. Review of Resident #1's October 2024 eMAR revealed: -There was an entry to check BP daily 10/01/24 to 10/22/24 at 7:00am. -There was an entry for clonidine 0.2mg daily as needed for a systolic blood pressure (SBP) > 160mmHg. -On 10/07/24, there was documentation the resident's BP was 176/98 and there was no documentation the clonidine was administered. Review of Resident #1's medications available for administration on 10/23/24 at 10:00am revealed there was a bubble pack of clonidine 0.2mg, with a label dated 08/16/24 containing 30 tablets, to administer 1 tablet as needed for a SBP > 160 with 30 tablets left to administer. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/23/24 at 11:35am revealed: -There was a signed physician's order dated 08/16/24 for clonidine 0.2mg daily as needed for a systolic blood pressure (SBP) > 160mmHg. -On 08/16/24, clonidine 0.2mg, 30 tablets (a 30-day supply) were dispensed to the facility. -Clonidine was not dispensed after 08/16/24. Interview with the Senior Resident Care Director (SRCD) on 10/23/24 at 12:30pm revealed: -The MAs were responsible for obtaining	D 358		

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D 358	Continued From page 14 Resident #1's BP and administering clonidine for a SBP > 160. -She did not know the SBP parameter was not entered in the eMAR with Resident #1's BP but with his PRN clonidine, therefore if the SBP was > 160, then the MA would not have been prompted to administer the PRN clonidine. -The MAs were responsible for medication cart audits where the MA compared the medication on hand to the eMAR. -She did not realize the way she taught the MAs to perform the medication cart audits did not include comparing the paper eMAR and orders to the medications on hand and the computer eMAR which would have caught the entry error for the SBP parameter /clonidine order. -She performed the medication cart audits the same way and did not catch the entry error for the SBP parameter /clonidine order. -She did not complete an audit Resident #1's vital sign sheet which contained Resident #1's BPs to make sure the clonidine was administered for a SBP > 160. Interview with Resident #1's Primary Care Provider (PCP) on 10/23/24 at 1:55pm revealed: -She ordered BP checks daily for Resident #1 and PRN clonidine to be administered for a SBP > 160. -The parameters were set in place to help be an early indication for the increased risk of a stroke. -She did not know Resident #1's SBP was > 160 three times in September 2024 until Resident #1's routine visit on 10/03/24. -On 10/03/24, she saw Resident #1 for a routine visit and during the review of his record she did not see a BP documented for Resident #1 that was considered a high risk for a stroke (SBP >200 and DBP >100).	D 358		

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D 358	Continued From page 15 Interview with a MA on 10/24/24 at 9:30am revealed: -She obtained Resident #1's BP every morning at 7:00am when she worked. -In August 2024, there was no place to enter the BP on the eMAR and reported it to the Senior Resident Care Director (SRCD) within the first week of the order. -On 09/01/24, the eMAR was changed and there was a place to document the BP's. -There were no parameters associated with Resident #1's BP. -Clonidine was on Resident #1's as needed list but there were no parameters associated with the BP so she was not directed to administer the clonidine. -She was told by the SRCD on 10/23/24, the BP parameters were on the clonidine order that's why the MAs never saw the parameters. -The second shift MAs were responsible for medication cart audits. -The medication cart audits were completed by comparing the medications on hand with the eMAR, so it was not likely the BP parameters would have been noticed on the clonidine order. Interview with a second MA on 10/24/24 at 9:40am revealed: -She obtained Resident #1's BP when she worked but did not know there were BP parameters to give clonidine because the parameters were on the clonidine PRN order in the eMAR. -Because the BP parameters were associated with the PRN clonidine, she was not prompted to administer clonidine for the BP' with SBP > 160. -There were 4 occasions between 09/01/24 and 10/22/24 Resident #1's SBP was > 160 and should have received clonidine. -The two Licensed Practical Nurses (LPN) and	D 358		

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D 358	Continued From page 16 the SRCD were responsible for faxing the orders to the pharmacy. -The LPNs and the SRCD were responsible for reviewing the eMAR and approving the orders after the pharmacy entered the orders into the eMAR. -She was responsible for following the eMAR to administer the medications. -Interview with an LPN on 10/24/24 at 9:59am revealed: -She began working and training at the facility about 09/01/24. -She was responsible for faxing orders to the pharmacy. -The SRCD was responsible for approving orders in the eMAR system once the pharmacy entered the orders on the eMAR and no audits performed because that was not a part of her training at this point. Interview with the Administrator on 10/23/24 at 12:30pm revealed he was not aware of any issues related to Resident #1's BP parameters/clonidine administration. Refer to Interview with the Administrator on 10/23/24 at 12:30pm. b. Review of the facility's Diabetic Quick Reference Guide dated July 2024 revealed: -SSI orders required high and low parameters for notification to the physician. -Parameters included a finger stick blood sugar (FSBS) <70 (hypoglycemia) and >400 (hyperglycemia). Review of Resident #1`'s hospital discharge summary dated 09/27/24 revealed: -A discharge diagnosis of pulmonary embolis	D 358		

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D 358	Continued From page 17 (PE), COVID-19 virus infection, primary hypertension, chronic obstructive disease (COPD and type 2 diabetes without complication. -There was an order to check a FSBS before meals and at bedtime. -There was an order for Fiasp insulin U-100 (a fast-acting insulin to treat high blood sugars), check FSBS before each meal and at bedtime and inject per SSI: FSBS: 151-160= 2 unit, 161-240= 4 units, 241-300= 6 units, 301-350= 8 units, 351-400= 10 units and FSBS > 400= 12 units and notify physician. Review of Resident #1's signed physician order dated 10/03/24 revealed: -An order for Fiasp insulin U-100, check FSBS in the AM prior to breakfast and give 5 units if FSBS is > 150. -An order for Fiasp insulin U-100, check FSBS in the PM prior to supper and give 8 units if FSBS is > 150. -Call physician if FSBS is <60 or >250. Review of Resident #1's September 2024 electronic Medication Administration Record (eMAR) for 09/27/24 to 09/30/2024 revealed: -There was not an entry for Fiasp insulin U-100, check FSBS before each meal and at bedtime and inject per SSI: FSBS: 151-160= 2 unit, 161-240= 4 units, 241-300= 6 units, 301-350= 8 units, 351-400= 10 units and FSBS > 400= 12 units and notify physician. -On 09/27/24 to 09/30/24, there was no documentation the FSBS was obtained at 6:00am, 11:00am, 4:00pm and 8:00pm. -On 09/27/24 to 09/30/24, there was no documentation the Fiasp insulin was administered at at 6:00am, 11:00am, 4:00pm and 8:00pm. -Resident #1's FSBS was not documented as	D 358		

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D 358	Continued From page 18 obtained for 16 out of 16 opportunities. Review of Resident #1's October 2024 electronic Medication Administration Record (eMAR) for 10/01/24 to 10/03/2024 revealed: -There was not an entry for Fiasp insulin U-100, check FSBS before each meal and at bedtime and inject per SSI: FSBS: 151-160= 2 unit, 161-240= 4 units, 241-300= 6 units, 301-350= 8 units, 351-400= 10 units and FSBS > 400= 12 units and notify physician. -On 10/01/24 to 10/03/24, there was no documentation the FSBS was obtained at 6:00am, 11:00am, 4:00pm and 8:00pm. -On 10/01/24 to 10/03/24, there was no documentation the Fiasp insulin was administered at at 6:00am, 11:00am, 4:00pm and 8:00pm. -Resident #1's FSBS was not documented as obtained for 12 out of 12 opportunities. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 10/23/24 at 11:35am revealed: -On 09/27/24, the pharmacy received a hospital discharge summary with an order for Fiasp insulin U-100 (a fast-acting insulin to treat high blood sugars), check FSBS before each meal and at bedtime and inject per SSI: FSBS: 151-160= 2 unit, 161-240= 4 units, 241-300= 6 units, 301-350= 8 units, 351-400= 10 units and FSBS > 400= 12 units and notify physician. -Due to an error on the pharmacy's part, the Fiasp insulin for the order dated 09/27/24 was never added to the eMAR and dispensed to the facility. -It was the facility's staff's responsibility to review the order placed into the eMAR system and approve all of the new orders.	D 358		

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D 358	Continued From page 19 Interview with the Senior Resident Care Director (SRCD) on 10/23/24 at 12:30pm revealed: -The MAs were responsible for medication cart audits where the MAs compared the medications on hand to the eMAR. -She did not realize the way she taught the MAs to perform the medication cart audits did not include comparing the paper eMAR and orders to the medications on hand and the computer eMAR which would have caught the missed hospital discharge order dated 09/27/24 for the new SSI order. -She performed the medication cart audits the same way and did not catch the missed hospital discharge order dated 09/27/24 for the new SSI order. -She did not complete an audit Resident #1's vital sign sheet which contained Resident #1's FSBS to make sure the amount of SSI was administered. Interview with a MA on 10/24/24 at 9:30am revealed: -She obtained Resident #1's FSBS every morning at 11:00am and 4:00pm when she worked. -On 09/27/24, Resident #1 returned from the hospital with orders attached to his hospital discharge summary. -The RCCs and the SRCD were responsible for faxing the hospital discharge summary orders to the pharmacy. -On 09/27/24 to 10/03/24 during the 7:00am and 4:00pm medication pass for residents with FSBS, there was no eMAR entry for SSI for Resident #1. Interview with Resident #1's Primary Care Provider (PCP) on 10/23/24 at 1:55pm revealed: -On 10/03/24, she saw Resident #1 for a routine visit and during the review of his record she found the 09/27/24 hospital discharge orders.	D 358		

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D 358	Continued From page 20 -Resident #1 was discharged from the hospital on 09/27/24 with SSI orders. -Resident #1's hospital discharge SSI orders were different than he had at the facility before the hospitalization. -The facility was to send her the 09/27/24 hospital discharge orders for her to review and approve to avoid issues with Resident #1's treatment plans and unnecessary changes to Resident #1's treatments for his diabetes. -She was not sent the hospital discharge orders for review and on 10/03/24, she changed Resident #1's SSI orders. -Interview with an LPN on 10/24/24 at 9:59am revealed: -She began working and training at the facility about 09/01/24. -She was responsible for faxing orders to the pharmacy. -She did not know if she faxed Resident #1's 09/27/24 hospital discharge summary orders to the pharmacy or if the SRCD did. -The SRCD was responsible for approving orders in the eMAR system once the pharmacy entered the orders on the eMAR and no audits performed because that was not a part of her training at this point. Interview with the Administrator on 10/23/24 at 12:30pm revealed he was not aware of any issues related to Resident #1's SSI administration. Refer to Interview with the Administrator on 10/23/24 at 12:30pm. c. Review of Resident #1's signed physician's order dated 10/03/24 revealed: -An order for Fiasp flex touch U-100 insulin,	D 358		

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D 358	Continued From page 21 check FSBS in the AM prior to breakfast and administer 5 units of Fiasp insulin for a FSBS > 150. -An order for Fiasp flex touch U-100 insulin, check FSBS in the PM prior to supper and administer 8 units of Fiasp insulin for a FSBS > 150. -An order to call PCP if FSBS was < 60 or > 250. Review of Resident #1's October 2024 eMAR revealed: -An entry for Fiasp flex touch U-100 insulin, check FSBS in the AM prior to breakfast and administer 5 units of Fiasp insulin for a FSBS > 150, call PCP if FSBS was < 60 or > 250. -On 10/06/24 at 7:30am, the FSBS was documented as 100 and 5 units of Fiasp insulin was administered instead of the holding the Fiasp insulin. -On 10/07/24 at 7:30am, the FSBS was documented as 113 and 5 units of Fiasp insulin was administered instead of the holding the Fiasp insulin. -On 10/08/24 at 7:30am, the FSBS was documented as 99 and 5 units of Fiasp insulin was administered instead of the holding the Fiasp insulin. -On 10/10/24 at 7:30am, the FSBS was documented as 107 and 5 units of Fiasp insulin was administered instead of the holding the Fiasp insulin. -On 10/11/24 at 7:30am, the FSBS was documented as 98 and 5 units of Fiasp insulin was administered instead of the holding the Fiasp insulin. -On 10/13/24 at 7:30am, the FSBS was documented as 107 and 5 units of Fiasp insulin was administered instead of the holding the Fiasp insulin. -On 10/15/24 at 7:30am, the FSBS was	D 358		

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D 358	Continued From page 22 documented as 100 and 5 units of Fiasp insulin was administered instead of the holding the Fiasp insulin. -On 10/16/24 at 7:30am, the FSBS was documented as 95 and 5 units of Fiasp insulin was administered instead of the holding the Fiasp insulin. -On 10/17/24 at 7:30am, the FSBS was documented as 95 and 5 units of Fiasp insulin was administered instead of the holding the Fiasp insulin. -On 10/18/24 at 7:30am, the FSBS was documented as 102 and 5 units of Fiasp insulin was administered instead of the holding the Fiasp insulin. -On 10/21/24 at 7:30am, the FSBS was documented as 106 and 5 units of Fiasp insulin was administered instead of the holding the Fiasp insulin. -An entry for Fiasp flex touch U-100 insulin, check FSBS in the PM prior to supper and administer 8 units of Fiasp insulin for a FSBS > 150, call PCP if FSBS was < 60 or > 250. -On 10/21/24 at 4:30pm, the FSBS was documented as 159 and 8 units of Fiasp insulin was administered. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 10/23/24 at 11:35am revealed: -There was an signed physician's order dated 10/04/24 for Fiasp flex touch U-100 insulin, check FSBS in the AM prior to breakfast and administer 5 units of Fiasp insulin for a FSBS > 150, and one Fiasp insulin pen (a 30 days supply), was dispensed to the facility. -An order for Fiasp flex touch U-100 insulin, check FSBS in the PM prior to supper and administer 8 units of Fiasp insulin for a FSBS > 150, and one Fiasp insulin pen (a 30 days	D 358		

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D 358	Continued From page 23 supply), was dispensed to the facility. Interview with the Senior Resident Care Director (SRCD) on 10/23/24 at 12:30pm revealed: -The MAs were responsible for reading Resident #1's FSBS and SSI order and only administer 5 units of insulin to Resident #1 at 7:30am if the FSBS was > 150 and 8 units of insulin at 4:30pm for a FSBS > 150. -She did not know the MA were administering 5 units of insulin at 7:00am for FSBS < 150 because she did not audit a printout of Resident #1's eMAR to see what insulin was administered. Interview with Resident #1's Primary Care Provider (PCP) on 10/23/24 at 1:55pm revealed: -On 10/03/24, she saw Resident #1 for a routine visit and during the review of his record she found the 09/27/24 hospital discharge orders. -Resident #1 was discharged from the hospital on 09/27/24 with SSI orders. -Resident #1's hospital discharge SSI orders were different than he had at the facility before the hospitalization. -The facility was to send her the 09/27/24 hospital discharge orders for her to review and approve to avoid issues with Resident #1's treatment plans and unnecessary changes to Resident #1's treatments for his diabetes. -She was not sent the hospital discharge orders for review and on 10/03/24, she changed Resident #1's SSI orders. Interview with a MA on 10/24/24 at 9:30am revealed: -She obtained Resident #1's FSBS every morning at 7:30am and 4:30pm when she worked. -On 10/04/24, Resident #1 had new orders for insulin administration. -In October 2024 she administered insulin for a	D 358		

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D 358	Continued From page 24 FSBS < 150 when she was supposed to hold it because she misread the order. Interview with the Administrator on 10/23/24 at 12:30pm revealed he was not aware of any issues related to Resident #1's SSI administration. Refer to Interview with the Administrator on 10/23/24 at 12:30pm. --- Interview with the Administrator on 10/23/24 at 12:30pm revealed: -The MAs were responsible for weekly medication cart audits where the MAs compared the medications available for administration to the computer eMAR. -The SRCD was responsible for the same medication cart audits monthly. -The Resident Care Coordinators (RCC) and the SRCD were responsible for at least monthly audits of resident vital sign/insulin sheets to make sure parameters for BPs and insulin were addressed as well as the correct SSI was administered. -After completion and review of those reports, the RCCs and the SRCD were responsible for making sure any issues were addressed with the PCP. -The SRCD was responsible for reporting to him every morning in the meeting any issues related to medication administration and PCP notification. 2. Review of Resident #5's FL-2 dated 07/25/24 revealed: -Diagnoses included altered mental status, macular degeneration, Charles Bonnet syndrome (a condition where one sees things that are not real) and a history of on-going urinary tract	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060019	A. BUILDING: _____ B. WING _____	R 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF CHARLOTTE	6000 PARK SOUTH DRIVE CHARLOTTE, NC 28210

(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 25 infections. -An order for Seroquel (a medication that treats behaviors) 25mg (1/2 tablet 12.5 mg) daily. Review of Resident #5's signed behavioral health provider orders dated 08/22/24 revealed: -An order to discontinue Seroquel (quetiapine) 25 mg ½ tablet (12.5mg) at bedtime. -An order to start Seroquel (quetiapine) 25 mg ½ tablet (12.5mg) in the morning. Review of Resident #5's neurologist order dated 10/09/24 revealed an order for quetiapine fumarate 25mg take ½ tablet (12.5mg) at bedtime. Review of Resident #5's August 2024 electronic medication administration record (eMAR) revealed: -There was entry for quetiapine 25mg take ½ tablet (12.5mg) at bedtime, scheduled between 7:00pm and 9:00pm. -There was no entry for quetiapine 25mg take ½ tablet (12.5mg) in the morning. -Quetiapine was documented as administered between 7:00pm and 9:00pm on 08/1/24 through 08/31/24. Review of Resident #5's September 2024 electronic medication administration record (eMAR) revealed: -There was entry for quetiapine 25mg take ½ tablet (12.5mg) at bedtime, scheduled between 7:00pm and 9:00pm. -There was no entry for quetiapine 25mg take ½ tablet (12.5mg) in the morning. -Quetiapine was documented as administered between 7:00pm and 9:00pm on 09/1/24 through 09/30/24.	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 26 Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed: -There was entry for quetiapine 25mg take ½ tablet (12.5mg) at bedtime, scheduled between 7:00pm and 9:00pm. -There was no entry for quetiapine 25mg take ½ tablet (12.5mg) in the morning. -Quetiapine was documented as administered between 7:00pm and 9:00pm on 10/1/24 through 10/09/24. Interview with a medication aide (MA) on 10/24/24 at 11:15am revealed: -She would know if medication should be administered at a different time by looking at the eMar. -She was not aware of any medication time changes for Resident #5's Seroquel as she always got it at bedtime. Interview with the Senior Resident Care Director (SRCD) on 10/23/24 at 8:22am revealed: -Medication orders are faxed to the pharmacist by one of the facility nurses or the SRCD. -The pharmacy puts the order on the eMar and the facility nurses would confirm the order to make sure the order is correct. -She was not aware of the facility doing any audits related to medications, but only confirmed the order received from the pharmacy. -The Pharmacists would complete the audits of the medications. A second interview was completed with the SRCD on 10/24/24 at 2:00pm revealed she could not identify who confirmed Resident #5's Seroquel time change from 08/22/24. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 10/23/24 at	D 358		

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D 358	Continued From page 27 08:44am revealed: -There was an order on 08/22/24 to discontinue the Seroquel 25 mg ½ tablet (12.5mg) at bedtime and start the Seroquel 25 mg ½ tablet (12.5mg) in the morning. -He was not sure how the facility's system worked regarding orders and who puts the order on the eMar. -The pharmacy representative who knew that information was not available. -There were no clinical adverse effects with it being given in the morning except the possibility of increase falls. A telephone interview with Resident #5's behavioral health provider on 10/24/2024 at 9:44am revealed: -She had not saw Resident #5 since 8/22/24. -She was not made aware the Seroquel time change was not implemented until the facility notified her 10/23/24. -She would have "caught this" when she saw Resident #5 in the next few weeks as she would do her own mediation reconciliation while at the facility. -Resident #5 is fine to have the Seroquel in the evening but she had wanted it in the morning. Attempted telephone interview with Resident #5's neurologist on 10/23/24 at 4:38pm was unsuccessful. Interview with the Administrator on 10/24/24 at 2:44pm revealed: -He was not aware of the Seroquel order not being changed to the morning. -The nurse was responsible for confirming the orders on the eMar. -It was his expectation that medication orders were approved and confirmed.	D 358		

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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). This Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to ensure the electronic medication administration records (eMAR) were accurate for 1 of 1 sampled residents (Resident #1) related to a medication used to treat high blood pressure and the parameters were not documented and the as needed (PRN) medication was not administered. The finding are: Review of Resident #1's current FL-2 dated 08/13/24 revealed:	D 367		

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D 367	Continued From page 29 -There was an order for daily blood pressure (BP) checks. -There was an order for clonidine (a medication used to treat high blood pressure) 0.2mg daily as needed (PRN) for a systolic blood pressure (SBP) > 160mmHg. Review of Resident #1's August 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check BP daily 08/19/24 at 7:00am to 08/31/24. -There was no BP documented 08/14/24 to 08/31/24. -There was an entry for clonidine 0.2mg daily as needed for a systolic blood pressure (SBP) > 160mmHg. -There was no documentation the clonidine was administered. Review of Resident #1's September 2024 eMAR revealed: -There was an entry to check BP daily 09/01/24 to 09/30/24 at 7:00am. -There was an entry for clonidine 0.2mg daily as needed for a systolic blood pressure (SBP) > 160mmHg. -On 09/09/24, there was documentation the resident's BP was 176/98 and there was no documentation the clonidine was administered. -On 09/15/24, there was documentation the resident's BP was 175/91 and there was no documentation the clonidine was administered. -On 09/29/24, there was documentation the resident's BP was 171/98 and there as no documentation the clonidine was administered. Review of Resident #1's October 2024 eMAR revealed: -There was an entry to check BP daily 10/01/24 to	D 367		

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D 367	Continued From page 30 10/22/24 at 7:00am. -There was an entry for clonidine 0.2mg daily as needed for a systolic blood pressure (SBP) > 160mmHg. -On 10/07/24, there was documentation the resident's BP was 176/98 and there was no documentation the clonidine was administered. Interview with the Senior Resident Care Director (SRCD) on 10/23/24 at 12:30pm revealed: -The MAs were responsible for obtaining Resident #1's BP, administering clonidine for a SBP > 160 and following up with the PCP when the SBP was > 160 or there was an issue with the order. -She did not know the SBP parameter was not entered in the eMAR with Resident #1's BP but with his PRN clonidine, therefore if the SBP was > 160, then the MA would not have been prompted to administer the PRN clonidine. -The MA were responsible for medication cart audits where the MA compared the medication on hand to the eMAR. -She did not realize the way she taught the MAs to perform the medication cart audits did not include comparing the paper eMAR and orders to the medications on hand and the computer eMAR which would have caught the entry error for the SBP parameter /clonidine order. -She performed the medication cart audits the same way and did not catch the entry error for the SBP parameter /clonidine order. -She did not complete an audit Resident #1's vital sign sheet which contained Resident #1's BPs to make sure the clonidine was administered for a SBP > 160. Interview with a MA on 10/24/24 at 9:40am revealed: -She obtained Resident #1's BP when she	D 367		

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D 367	Continued From page 31 worked but did not know there were BP parameters to give clonidine because the parameters were on the clonidine PRN order in the eMAR. -Because the BP parameters were associated with the PRN clonidine, she was not prompted to administer clonidine for the BP' with SBP > 160. -There were 4 occasions between 09/01/24 and 10/22/24 Resident #1's SBP was > 160 and should have received clonidine. -She was responsible for following the eMAR to administer the medications. -She would have been responsible for notification to Resident #1's PCP for a SBP > 160 had the order been attached to the BPs not the PRN clonidine. Interview with the Administrator on 10/23/24 at 12:30pm revealed: -He was not aware of any issues related to any errors on the eMARs for Resident #1's BP parameters/clonidine. -The MAs were responsible for weekly medication cart audits where the MAs compared the medications available for administration to the computer eMAR. -The SRCD was responsible for the same medication cart audits on a monthly basis. -After completion and review of those reports, the RCCs and the SRCD were responsible for making sure any issues were addressed with the PCP.	D 367		

Sunrise Senior Living
Plan of Correction

Name of Community: Brighton Gardens of Charlotte
Address of Community: 6000 Park S Dr. Charlotte, NC 28210
License number: HAL-060-019
Inspection date(s): 10/22/2024
Name/Title of Legal Entity Representative Signing the Plan of Correction:
Paul Akosah, Executive Director

Signature of Sunrise Representative: Paul Akosah, Executive Director 11/27/24
Date of Submission: Due 11/29/2024

Regulation	Target Date by Which Correction will be completed	Plan of Correction
D 273 10A NCAC 13F.09.02 (b) The facility shall assure referral and follow-up to meet the routine and acute health needs of residents	11/27/24	***A. With respect to the specific resident/situation cited:*** Resident #4 Sr. Resident Care Director completed PT/OT/ST referral and submitted 3rd party vendor on 10/23/24. Health-Pro could not pick up resident due to insurance coverage. Resident Care Director faxed referral over to Bayada on 10/24/2024 and was not pickup by that vendor either. New referral obtained and services to start. ***B. With respect to how the facility will identify residents/situations for the identified concerns:*** Resident Care Director will conduct an audit of resident receiving orders for PT/OT/ST to ensure orders were written correctly and therapy is implemented and documented. Orders found to be in error will be clarified, documented and implemented. **C. *With respect to what systemic measures have been put into place to address the stated concern:*** Resident Care Director or designee have in serviced 3rd party vendor to give all referrals to the Resident Care Director or designee. Wellness Nurse or designee will notify Executive Director or Resident Care Director if any orders are received for PT/OT/ST. Executive Director or designee will audit resident orders to confirm documentation and initiation of services monthly for 3 months. ***D. With respect to how the plan of correction will be monitored:*** The Executive Director and/or designee will report findings of
	11/26/24	
	11/25/24	
	12/11/24	

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		the audits to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after this time, the QAPI Team will re-evaluate and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.
D 358 10 A NCAC 13F .1004 (a) Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: 1) Orders by a licensed prescribing practitioner which are maintained in the resident's record; and 2) Rules in this section and the facility's policies and procedures	10/24/24 10/24/24 10/24/24 10/24/24 11/26/24	***A. With respect to the specific resident/situation cited:*** Sr. Resident Care Director clarified clonidine order and corrected eMar to reflect if blood pressure systolic is over 160, clonidine is to be administered for resident #1. Order has now been discontinued by Primary Care Physician. Sr. Resident Care Director clarified order for insulin and verified eMar orders were entered correctly for Resident #1. For resident #5, Sr. Resident Care Director clarified order for Seroquel and APRN from Behavioral Health stated resident was stable on current dose and directed for order to continue as is. ***B. With respect to how the facility will identify residents/situations for the identified concerns:*** Sr. Resident Care Director held in-service regarding medication processes and procedures to include documentation. Paying close attention to eMAR to make sure orders are correct and instructed to notify Resident Care Director/or designee if sliding scale insulin units are missing or outside parameters. Sr. Resident Care Director will conduct an audit of diabetic residents' charts to confirm sliding scale insulin orders with parameters are reflected accurately on the eMAR. Orders found to be incorrect will be clarified and updated in eMAR. Sr. Resident Care Director will conduct an audit of hypertensive residents' charts to confirm orders with parameters are reflected

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	11/272024 12/11/24	accurately on the eMAR. Orders found to be incorrect will be clarified and updated in eMAR. ***C. With respect to what systemic measures have been put into place to address the stated concern:*** Sr. Resident Care Director or designee will conduct weekly random audits of residents with parameters for 3 weeks and then monthly for 3 months to confirm that medication technicians are documenting correctly. Disciplinary action will be delivered for any documentation found out of compliance. Wellness Nurse or designee will notify Executive Director or Resident Care Director if any orders are received for sliding scale. Executive Director or designee will audit eMAR orders to confirm units given are reflected on MAR monthly for 3 months. ***D. With respect to how the plan of correction will be monitored:*** The Executive Director and/or designee will report findings of the audits to the Quality Assurance Performance Improvement Committee Monthly for 3 months. During and after this time, the QAPI Team will re-evaluate and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.
D 367 10 A NCAC 13F .1004 (j) Medication Administration The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the	10/24/24 11/26/24	***A. With respect to the specific resident/situation cited:*** Sr. Resident Care Director clarified clonidine order and corrected eMar to reflect if blood pressure systolic is over 160, clonidine is to be administered for resident #1. Order has now been discontinued by Primary Care Physician. ***B. With respect to how the facility will identify residents/situations for the identified concerns:*** Sr. Resident Care Director will conduct an audit of residents with orders to monitor blood pressure to confirm orders has parameters

Regulation	Target Date by Which Correction will be completed	Plan of Correction
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	11/27/24 12/11/24	and are reflected on the EMARs. Orders found to be in error will be clarified and resolved. ***C. With respect to what systemic measures have been put into place to address the stated concern:*** Sr. Resident Care Director or designee will conduct weekly random audits of residents with parameters for 3 weeks and then monthly for 3 months to confirm that medication technicians are documenting correctly. Disciplinary action will be delivered for any documentation found out of compliance. Wellness Nurse or designee will notify Executive Director or Resident Care Director if any orders are received for sliding scale. Executive Director or designee will audit eMAR orders to confirm units given are reflected on MAR monthly for 3 months. ***D. With respect to how the plan of correction will be monitored:*** The Executive Director and/or designee will report findings of the audits to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after this time, the QAPI Team will re-evaluate and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.