STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-013-05	A. BUILDING: _____ B. WING _____	R 01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN STREET SENIOR LIVING	302 ANN STREET KANNAPOLIS, NC 28081

(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
C 000	Initial Comments The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted an annual survey and follow-up on 01/02/25.	C 000		
C 282	10A NCAC 13G .0904 (e)(2) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service (e)Therapeutic Diets in Family Care Homes: (2) Physician orders for nutritional supplements shall be in writing from the resident's physician and be brand-specific, unless the facility has defined a house supplement in its communication to the physician, and shall specify quantity and frequency. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure 1 of 1 sampled resident (Resident #3) had a written physician's order for a nutritional supplement that was brand specific and specified the quantity and frequency. The findings are: Review of Resident #3's current FL2 dated 06/20/24 revealed: -Diagnoses included chronic obstructive pulmonary disease, hyperlipidemia, vascular dementia, leukopenia, anemia, and right inguinal hernia. -Nutritional status included "regular diet", "supplemental" and "intake and output".	C 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-013-05	A. BUILDING: _____ B. WING _____	R 01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN STREET SENIOR LIVING	302 ANN STREET KANNAPOLIS, NC 28081

(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
C 282	Continued From page 1 Review of Resident #3's Resident Register revealed an admission date of 05/27/23. Review of Resident #3's record on 01/02/24 revealed there was no written physician order for a brand specific nutritional supplement. Interview with the Supervisor in Charge (SIC) on 01/02/24 at 12:06pm revealed: -Resident #3 received a nutritional drink (Boost) with every meal. Interview with the Administrator on 01/02/24 at 12:10pm revealed: -When an FL2 was received, she reviewed the medications. -She thought Resident #3's diet order was for a regular diet. -Resident #3 did not receive a nutritional supplement. -She purchased nutritional drinks (Boost). -Resident #3 was oriented and asked for Boost and she gave it to him. -Resident #3 received Boost with each meal. -Resident #3's daughter bought Boost and brought it to the facility for him. Interview with Resident #3's physician on 01/02/24 at 2:00pm revealed: - There was not a physician order for nutritional supplements in writing or brand-specific, nor did the facility define a house supplement in its communication to the resident's physician specifying quantity and frequency in the resident's medical record. -Nutritional status ("regular diet", "supplemental" , and "intake and output") that was listed on the adult's FL2 was carried over from a previous FL2 prior to his admission at the facility.	C 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-013-05	A. BUILDING: _____ B. WING _____	R 01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN STREET SENIOR LIVING	302 ANN STREET KANNAPOLIS, NC 28081

(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
C 282	Continued From page 2 Interview with the Administrator and facility nurse on 01/02/24 at 4:58pm revealed: -FL2s were to be reviewed thouroughly and if there was information that wasn't clear, they sent a clarification form to the provider. -If a diet order was to include a nutritional supplement and it was not clear what brand to administer or how and when to give it, they were to send a clarification form to the provider.	C 282		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 record reviews and interviews the facility failed ensure medications were administered as ordered for 1 of 3 sampled residents (Resident #2) related to oxygen. The findings are: Review of Resident #2's current FL2 dated 12/10/24 revealed: -Diagnoses included dementia, adult failure to thrive, hypertension and hyperlipidemia. -She required oxygen 2 liters continuous via nasal cannula.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-013-05	A. BUILDING: _____ B. WING _____	R 01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN STREET SENIOR LIVING	302 ANN STREET KANNAPOLIS, NC 28081

(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
C 330	Continued From page 3 Review of Resident #2's Resident Register revealed an admission date of 12/13/24. Review of hospital discharge summary dated 12/15/24 revealed: -Resident #2 was transported to a new facility on 12/13/24 and was without her oxygen for about forty minutes. -Resident #2 was normally maintained upon 2 liters nasal cannula oxygen continuously. -Facility staff were unable to maintain Resident #2's oxygen levels above 90 percent. -Emergency Medical Services (EMS) was contacted after an hour of Resident #2 being at the facility. -EMS placed Resident #2 on a nonrebreather and administered a nebulizer treatment. -Resident #2 was subsequently transferred to the emergency room for further evaluation and treatment. -Resident #2 remained on oxygen 2 liters and maintained an oxygen saturation of 99 percent (normal range 90-100). -Resident #2 received x-rays, scans and lab workup and was diagnosed with acute cystitis with hematuria and urinary tract infection. -Resident #2 returned to the facility with a prescription for Macrobid 100mg, 1 capsule by mouth twice daily for 10 days. -Resident #2 was to continue with docusate, metoprolol, omeprazole and sucralfate. Review of Resident #2's record revealed she was admitted to hospice on 12/16/24 and was receiving continuous oxygen 2 liters. Review of Resident #2's December 2024 electronic medication administration record (eMAR) revealed:	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-013-05	A. BUILDING: _____ B. WING _____	R 01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN STREET SENIOR LIVING	302 ANN STREET KANNAPOLIS, NC 28081

(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
C 330	Continued From page 4 -There was no documentation of continuous oxygen between 12/15/24 through 12/19/24. -Documentation for continuous oxygen was not entered until 12/20/24 through 12/31/24. Review of the January 2025 eMAR revealed there was documentation of continuous oxygen 2 liters being administered to Resident #2 from 01/01/25 to 01/02/25. Interview with the Administrator on 01/02/25 at 1:04pm revealed: -Resident #2 should have been arrived at the facility with oxygen. -Resident #2 was transported for admission to the facility by her family member and did not have oxygen. -Resident #2's oxygen level was low upon arrival. -She administered oxygen to Resident #2 upon arrival then sent her to the emergency room due to unstable oxygen levels. -Resident #2 was discharged from the hospital after being stabilized and continued with continuous oxygen 2 liters per hospital call report. -Resident #2's FL2 showed she had an order for oxygen 2 liters continuously. -Resident #2 did receive continuous oxygen 2 liters although it was not documented on the eMAR. -Resident #2's oxygen was not entered as an order or entered on the eMAR until 12/20/24. -Resident #2's oxygen should have been entered on the eMAR and documented as given when she returned from the hospital 12/15/24 through 12/19/24. -She and/ or the facility nurse were responsible for entering the oxygen on the eMAR since it was not the pharmacy's responsibility to do so. -She expected Resident #2's oxygen order to be followed and documented on the eMAR.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-013-05	A. BUILDING: _____ B. WING _____	R 01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN STREET SENIOR LIVING	302 ANN STREET KANNAPOLIS, NC 28081

(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
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .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 observations, record reviews and interviews the facility failed to ensure electronic medication administration records (eMAR) were accurate for 1 of 3 sampled residents (Resident #2) related to documenting oxygen. The findings are: Review of Resident #2's current FL2 dated 12/10/24 revealed: -Diagnoses included dementia, adult failure to thrive, hypertension and hyperlipidemia. -She required oxygen two (2) liters continuous.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-013-05	A. BUILDING: _____ B. WING _____	R 01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN STREET SENIOR LIVING	302 ANN STREET KANNAPOLIS, NC 28081

(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
C 342	Continued From page 6 Review of Resident #2's Resident Register revealed an admission date of 12/13/24. Review of Resident #2's record revealed she was admitted to hospice on 12/16/24 and was receiving continuous oxygen 2 liters. Review of the December 2024 eMAR revealed: -There was no documentation of continuous oxygen between 12/15/24 through 12/19/24. -Documentation for continuous oxygen was not entered until 12/20/24 through 12/31/24. Review of the January 2025 eMAR revealed there was documentation of continuous oxygen 2 liters being administered to Resident #2 from 01/01/25 to 01/02/25. Interview with the Administrator on 01/02/25 at 1:04pm revealed: -Resident #2 should have been arrived at the facility with oxygen. -Resident #2 was transported for admission to the facility by her family member and did not have oxygen. -Resident #2's oxygen level was low upon arrival. -She administered oxygen to Resident #2 upon arrival then sent her to the emergency room due to unstable oxygen levels. -Resident #2 was discharged from the hospital after being stabilized and continued with continuous oxygen 2 liters per hospital call report. -Resident #2 did receive continuous oxygen 2 liters although it was not documented on the eMAR. -Resident #2's oxygen was not entered as an order or entered on the eMAR until 12/20/24. -Resident #2's oxygen should have been entered on the eMAR and documented as given when	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-013-05	A. BUILDING: _____ B. WING _____	R 01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN STREET SENIOR LIVING	302 ANN STREET KANNAPOLIS, NC 28081

(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
C 342	Continued From page 7 she returned from the hospital 12/15/24 through 12/19/24. -She and/ or the facility nurse were responsible for entering the oxygen on the eMAR since it was not the pharmacy's responsibility to do so. -She expected Resident #2's oxygen to be reflected on the eMAR and documented appropriately.	C 342		