Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060001	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HILLS	2801 CARMEL ROAD CHARLOTTE, NC 28226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey and complaint investigation from February 25, 2026 to February 26, 2026.	D 000	10A NCAC 13F 1002(a) Medication Orders Resident #2 As indicated in the findings the order was not clear. The Oxygen order was discontinued	
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure medication orders were clarified for 1 of 5 sampled residents (#2), related to oxygen. The findings are: Review of Resident #2's current FL2 dated 02/17/26 revealed: -Resident #2's diagnoses included hypothyroidism, osteoporosis, macular degeneration, glaucoma, anxiety and hypertension.	D 344		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Carolyn Brockington, RN MSN — 3/27/26

Signed & Acknowledged 3/31/26 Faheemah Jones

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D 344	Continued From page 1 -Resident #2 was semi-ambulatory. -Resident #2 was intermittently disoriented. Review of Resident #2's Resident Register revealed an admission date of 05/12/23. Review of Resident #2's Nurse Practitioner (NP) progress note dated 02/17/26 revealed: -Resident #2 had increased fatigue and low energy. -Resident #2 should be administered oxygen as needed to maintain an oxygen saturation above 90%. -Resident #2's oxygen saturation level dropped to 85% on room air after the visit. -The duration of oxygen use was continuous. -There was no direction on how often to check Resident #2's oxygen saturation levels to determine if her levels were less than 90% and oxygen was needed. Review of Resident #2's record revealed a written physician's order dated 02/17/26 revealed: -Administer oxygen 2 liters per minute via nasal cannula at bedtime and for saturation levels less than 90%. -There was no direction on how often to check Resident #2's oxygen saturation levels to determine if her levels were less than 90% and oxygen was needed. Review of a physician order summary dated 02/17/26 revealed: -Resident #4 had an order for oxygen, administer 2 liters per minute via nasal cannula once daily at bedtime and as needed for saturation less than 90%. -There was no direction on how often to check Resident #2's oxygen saturation levels to determine if her levels were less than 90% and	D 344	To ensure Oxygen orders are correctly written the use of the following order sheet is enclosed for review. Oxygen will read as follows. Resident Name: Oxygen Order: LPM/_____ Via (Please Check Below) Nasal Cannula _____ /Mask_____ (Please Check) Continuous/____ As needed: ____ O2 SAT Check every _____ MD/NP Signature: ____ Staff signature _____ Continued on next page	3-3-26

Carolyn Brockington, RN MSN 3/27/26

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D 344	Continued From page 2 oxygen was needed. Review of Resident #2's February 2026 electronic medication records (eMAR) reveealed: -There was an entry for oxygen, administer 2 liters per minute via nasal cannula once daily at bedtime and as needed for saturation less than 90%. -There was no direction for how often to check Resident #2's oxygen saturation levels to determine if her levels were less than 90% and oxygen was needed. Interview with the Resident Care Coordinator (RCC) on 02/26/26 at 11:00am revealed: -She was responsible for maintaining orders after she received them from the provider and the pharmacy. -She did not realize Resident #2's oxygen order needed clarification. -Resident #2's saturation levels were checked at bedtime. -Resident #2's oxygen order should have been clarified for bedtime as needed only or as needed at anytime during the day and when to check for saturation levels less than 90%. Interview with the NP on 02/26/26 at 10:26am revealed: -She wrote the oxygen order due to Resident #2's family's request. -She should have clarified if the oxygen at bedtime was scheduled or as needed. -She should have clarified when to check Resident #2's saturation levels to determine if her levels were less than 90% and oxygen was needed at other times of the day or just at bedtime.	D 344	To assure compliance charts and orders will be audited monthly by the Registered Nurse or the Clinical Care coordinator monthly	3/27/26

Carolyn Buckington, RN MSN 3/27/26

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D 344	Continued From page 3 Interview with the Administrator on 02/26/26 at 11:00am revealed: -Resident #2's oxygen order should have been clarified to indicate when to check saturation levels and whether bedtime oxygen was the only time oxygen would be administered as needed. -She expected medication orders to be clarified if unclear.	D 344	10A NCAC 13F 1201(a) Resident Record: As indicated in the findings and per family Resident #2 was sent out to the ER to be evaluated X-ray/ CT scan completed due to head injury (laceration). Outdated MAR	
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health	D 433	SEE BELOW	

Carolyn Brockington, RNMSN 3/27/26

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D 433	Continued From page 4 professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the current electronic Medication Administration Record (eMAR) was sent with 1 of 1 resident (#2) when the resident was transferred to the local emergency department (ED). The findings are: Review of Resident #2's current FL2 dated 02/17/26 revealed: -Resident #2's diagnoses included hypothyroidism, osteoporosis, macular degeneration, glaucoma, anxiety and hypertension. -Resident #2 was semi-ambulatory. -Resident #2 was intermittently disoriented. Review of Resident #2's Resident Register revealed an admission date of 05/12/23. Review of Resident #2's record revealed a physician order (05/07/25) to discontinue Eliquis 5mg (a medication used to treat reduce the risk of	D 433	To ensure the correct and current information is sent with the resident the plan of correction is as follows: The following plan of correction was implemented on 3/23/2026 Check list for Emergency Transport Package on each chart Check List:- Emergency Package includes: 1) Advance Directive 2) Face Sheet 3) Insurance information 4) Current MAR – print at time of departure Return to Facility: Date Check list signed by Staff member and initialed for accuracy by Medic or family member: 1) Advance Directive 2) Discharge Summary 3) New Orders Cont. below	3-24-26

Carolyn Brockington, RN MSN 3/27/26

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D 433	Continued From page 5 blood clots). Review of Resident #2's eMAR for April 2025 revealed an entry for Eliquis 5mg tablets, take one tablet by mouth twice daily with a stop date of 05/08/25. Review of Resident #2's eMAR for November 2025 revealed no entry for Eliquis. Review of Resident #2's hospital discharge summary dated 11/4/25 revealed: -Resident was transferred to the ED due to a fall and head laceration. -An eMAR for April 2025 with an entry for Eliquis 5mg tablet, take one tablet by mouth twice daily, was sent with Resident #2 when she was transferred to the ED on 11/04/25. -Resident #2 was treated as a trauma activation (specialized team of hospital personnel who treat severe/ life threatening injuries) patient due to taking Eliquis. -Resident #2 received a head CT scan and C-spine due to her age and being on Eliquis. -The incorrect eMAR dated April 2025 was sent with Resident #2 to the ED. -It was later determined Resident #2 stopped taking Eliquis in May 2025, although the facility paperwork/ eMAR reported she was still taking Eliquis. -Resident #2 was discharged back to the facility per the responsible party's request. Interview with the Resident Care Coordinator (RCC) on 02/26/26 at revealed: -Transfer packets containing the resident face sheet, insurance information, code status, and eMAR accompanied residents to the ED. -The medication aides (MA) were responsible for ensuring the transfer packet contained the correct	D 433	Check list signed by Staff member and initialed for accuracy by Medic or family member STAFF MEMBER _____ MEDIC/ FAMILY _____ Staff Education To assure compliance all check off list will be reviewed and signed off by RN or Resident Care Coordinator within 24 hours of transfer and return Staff education provided	3/24/26 3/27/26

Carolyn Brackington, RN MSN 3/27/26

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D 433	Continued From page 6 and up-to-date information before residents were transferred to the ED or appointments. -She did not know why the (six-month-old) April 2025 eMAR was sent to the ED with Resident #2 instead of her eMAR at the time for November 2025. Interview with the Administrator on 02/26/26 at revealed: -She was made aware the incorrect facility paperwork/ eMAR was sent to the ED with Resident #2, until the resident's family member mentioned it during a recent meeting. -She did not know how the April 2025 eMAR was sent since there should have been a transfer packet that should have included her face sheet, any advance care directives and MARs. -She expected the current/ correct paperwork to be transferred to the ED with residents.	D 433		

Carolyn Brockington, RN MSN 3/27/26