STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINT HILL SENIOR LIVING	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 September 17-19, 2024.	D 000		
D 262	10A NCAC 13F .0802 (d) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (d) The assessor shall sign the care plan upon its completion. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 4 of 5 sampled residents had accurate care plans signed by the assessor upon completion (#1, #2, #4 and #5). Review of the facility's Resident Assessment and Care Planning policy dated September 2021 revealed the assessor was to sign the plan of care. 1. Review of Resident #1's current FL2 dated 02/07/24 revealed diagnoses included major depressive disorder, hypertension, and dementia. Review of Resident #1's Resident Register revealed she was admitted to the Assisted Living on 12/19/19. Review of Resident #1's Care Plan dated 02/28/24 revealed: -Resident #1 required limited physical assistance with eating, ambulation, and transfers. -Resident #1 required extensive physical assistance with toileting, bathing, dressing and grooming. -The care plan was not signed by the assessor.	D 262		

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D 262	Continued From page 1 Refer to the interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:05am. Refer to the interview with the Administrator on 09/19/24 at 11:57am. 2. Review of Resident #4's current FL2 dated 10/05/23 revealed: -Diagnoses included chronic obstructive pulmonary disease, morbid obesity, schizoaffective disorder, generalized anxiety, and functional urinary incontinence. -Resident #4 was admitted to the facility on 05/04/23. Review of Resident #4's Care Plan dated 03/04/24 revealed: -Resident #4 was independent with ambulation and transfers. -She required extensive assistance with toileting, bathing, dressing, and grooming. -The care plan was not signed by the assessor. Refer to the interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:05am. Refer to the interview with the Administrator on 09/19/24 at 11:57am. 3. Review of Resident #2's current FL2 dated 11/10/23 revealed: -Diagnoses included diabetes mellitus, anemia, asthma, and chronic obstructive pulmonary disease. -Resident #2 was admitted to the facility on 11/01/23. Review of Resident #2's care plan dated 03/04/24 revealed:	D 262		

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D 262	Continued From page 2 -Resident #2 was independent with eating, toileting, ambulation, dressing, and mobility. -The care plan was not signed by the assessor. Refer to the interview with the RCC on 09/19/24 at 11:05am. Refer to the interview with the Administrator on 09/19/24 at 11:57am. 4. Review of Resident #5's current FL2 dated 05/02/24 revealed: -Diagnoses included hemiparesis of the right side (right side weakness), hypertension, chronic kidney disease, history of cerebrovascular accident (another term for a stroke) and controlled diabetes mellitus. -Resident #5 was admitted to the facility to the facility on 12/22/20. Review of Resident #5's care plan dated 02/28/24 revealed: -Resident #5 was independent for ambulation and mobility and needed limited assistance for eating, toileting, bathing, dressing, and grooming. -The care plan was not signed by the assessor. Refer to the interview with the RCC on 09/19/24 at 11:05am. Refer to the interview with the Administrator on 09/19/24 at 11:57am. _____ Interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:05am revealed: -It was the responsibility of the RCC to complete the care plans and have them ready for the Primary Care Provider (PCP) to sign. -She was the interim RCC and started August 27, 2024, and would be on site until a new staff	D 262		

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D 262	Continued From page 3 member was hired. -She was not aware some residents' care plans were not signed by the assessor. -The RCC was to complete the care plan and sign the care plan as the assessor. -The RCC was to do random chart audits at least weekly but did not know when the last one was completed. -The RCC and Administrator would do random chart audits weekly with the goal of finishing all resident charts monthly. Interview with the Administrator on 09/19/24 at 11:57am revealed: -The RCC was responsible for the care plan being signed within 15 days of the assessment. -She started August 27, 2024, and was not aware if audits had been completed prior to her starting but auditing of the charts was on her list. -She and the RCC would begin auditing charts next week with the goal of having all resident charts audited every six months. -Her expectations were for all care plans to be signed by the assessor.	D 262		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the	D 263		

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D 263	Continued From page 4	D 263		

care plan.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure 1 of 5 sampled residents had an accurate care plan signed by their provider within 15 days of the resident being assessed (#5).

The findings are:

Review of Resident #5's Resident Register revealed he was admitted to the facility on 12/22/20.

Review of Resident #5's current FL2 dated 05/02/24 revealed:
-Diagnoses included hemiparesis of the right side (muscle weakness of the right side), hypertension, history of cerebrovascular accident (stroke) and controlled diabetes mellitus.

Review of Resident #5's care plan dated 02/28/24 revealed:
-Resident #5 was independent for ambulation with the assistance of a wheelchair.
-Resident #5 needed limited assistance for eating, toileting, bathing, dressing, and grooming.
-The care plan was not signed by the primary care physician (PCP).

Interview with the PCP on 09/19/24 at 9:52am revealed:
-She came to the facility weekly to see residents and reviewed orders.
-The facility had a folder for paperwork she needed to sign and if the care plan was not in there then it was not signed.
-Sometimes the facility faxed care plans to the office and the office would fax them back, but she

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D 263	Continued From page 5 did not remember signing a care plan for Resident #5. Interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:05am revealed: -She was the interim RCC and started August 27, 2024, and would be on site until a new staff member was hired. -She was not aware Resident #5's care plan was not signed by the PCP. -The care plan was either faxed to the PCP office or put in the PCP file for their signature. -The RCC was to do random chart audits at least weekly but did not know when the last one was completed. Interview with the Administrator on 09/19/24 at 11:57am revealed: -The RCC was responsible for the care plan being signed within 15 days of the assessment. -She started August 27, 2024, and was not aware if audits had been completed prior to her starting but auditing of the charts was on her list. -Her expectations are for all care plans to be signed by the PCP within 15 days of the assessment.	D 263		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference,	D 283		

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D 283	Continued From page 6 including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the foods stored and prepared in the kitchen were free from contamination related to buildup of grease on the stove and shelves, a dirty walk-in cooler, floors, ice machine ledge, fresh fruit being stored on the floor in the walk-in and desserts left uncovered in the walk-in cooler. The Findings are: Observation of the stove on 09/17/24 at 11:18am revealed: -There was a build-up of brown baked on food on the front of the stove, which ran down the right side of the stove. -The shelf above the stove and flat-top grill had a thick layer of grease and food particles. Observation of the walk-in cooler in the kitchen on 09/17/24 at 11:30am to 11:38am revealed: -There was a mobile sheet pan rack with 3 trays of cupcakes/doughnuts (with approximately 12 cupcake/doughnuts on each tray) that were uncovered. -The ceiling had several dust particles hanging from the ceiling -There was a case of honeydew melons in a cardboard box sitting on the cement floor.	D 283		

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-There was puddle of liquid substance saturating the floor mat and seeping out onto other areas of the floor.
-The floors were sticky and covered with brown buildup.
-There were white and brown particles of food crumbs on the floor in between the shelves.

Observation of the floor in the dry storage area on 09/17/24 at 11:43am revealed the floors were sticky and covered in a black substance.

Observation of the preparation table lower shelf on 09/17/24 at 11:44am revealed:
-A utensil bin with the cover removed and lying on the shelf, the cover had black particles on the top of the lid and brown specks.
-The shelf had a build-up of particles of dust and grease.
-The electrical box to the lower left of the steam table was covered with a thick brown substance with white specks and pieces of tinfoil.

Observation of the outside of the ice machine on 0917/24 at 11:45am revealed white speckles and dust all over the front ledge.

Observation of an oscillating floor fan on 09/17/24 at 12:18pm revealed it was covered in dirt and dust and was plugged in and running.

Review of the local Environmental Health Services (EHS) Inspection Report dated 06/12/24 revealed:
-The kitchen received a score of 97.5.
-The inspector noted the floors, walls, ceilings, including the attachments such as soap, towel dispensers, light fixtures, and heat/ac vent covers shall be clean. Caution should be used to minimize food exposure. Observed general

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D 283	Continued From page 8	D 283		

cleaning needing to flooring under and behind equipment throughout the kitchen.

Interview with a dietary aide on 09/17/24 at 11:43am revealed:
-At the end of her shift yesterday (09/16/24) the floor was not wet.
-She did notice liquid in the walk-in cooler this morning (09/17/24) around breakfast time (8:00am).
-She was not sure what happened.
-She told the Dietary Manager (DM) about it.
-She did not have a cleaning checklist to guide her on cleaning.
-she would just "clean as she goes" and specified, wiping down the counters, sweeping and mopping.
-It was just her and the DM in the kitchen, so it was busy.

A second interview with the dietary aide on 09/18/24 at 10:43am revealed:
-She should have covered the cupcakes that were in the walk-in cooler.
-She was in a hurry and did not have time.
-She had gotten to work on 09/17/24 at 5:30 am and saw the rug was wet.
-Any of us could have cleaned it up but we did not have time as we had to get breakfast out.
-Deliveries come on Wednesday's and the delivery person will put the cold storage in the walk-in cooler.
-The melons had been sitting on the floor since last Wednesday.
-All the kitchen staff are responsible for putting the food on the shelves and it should have been done.
-They had been trying to buy bins to put things like the honeydew melons, but it had gotten too expensive.

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D 283	Continued From page 9 Interview with the cook on 09/18/24 at 11:00 am revealed: -He did not work on 09/17/24. -Desserts if put in the refrigerator should be wrapped. -He or the dietary aide would be responsible to wrap any food such as desserts while holding in the walk-in cooler. -The last delivery came on Wednesday 09/11/24. -He had worked the weekend but did not recall if the honeydew melon was on the floor. -He did not have a cleaning checklist to guide him but after cooking he would be responsible take out the trash, wipe down the counters and would clean anything that he used. -Other dietary staff also clean. Interview with the DM on 09/18/24 at 3:11pm revealed: -She had been with the company since March of 2024. -She noticed the spill in the walk-in cooler on 09/17/24 in the morning and thought it may had been water. -She was trying to get lunch ready and did not have time to clean it up. -She and the cook were responsible for making sure food items were not stored on the floor. -All food items should be covered in the refrigerator and whoever is putting the food in the walk-in cooler would be responsible to cover the food. -She was responsible for ensuring the cleaning in the kitchen was completed. -She did not have a cleaning checklist but was working on it. -They were short staffed in the kitchen and "we just clean as we go". -She had never cleaned the ceiling of the walk-in	D 283		

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D 283	Continued From page 10 cooler but had cleaned the shelves in the walk-in cooler. -She thought the daily tasks of cleaning should include wiping down the counters, pull out the stove and sweep out from behind, move the long serving table and scrub the stove. -The last time the stove was cleaned was two months ago, but the burners were cleaned last week. -She was not sure who would clean the fan but thought it should be thrown out. Interview with the maintenance manager on 09/17/24 at 11:30am revealed that he believed the equipment in the walk-in cooler was working properly and thought the liquid on the floor was from a spill. Interview with the Administrator in the walk-in cooler on 09/17/24 at 11:35am revealed: -The cupcakes should have been covered. -The melon should had been kept on a shelf. Interview with the Administrator on 09/18/24 at 11:56am revealed it was her expectation that the kitchen would be cleaned.	D 283		
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.	D 358		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#1 and #3) related to a medication used to treat spasms in the bowels(#1) and a medication used to treat high blood pressure (#3).

The findings are:

1. Review of Resident #1's current FL2 dated 02/07/24 revealed diagnoses included dementia, hypertension, lupus (a disease that causes the immune system to attack healthy tissue and cells), and cerebrovascular accident (stroke).

Review of Resident #1's Emergency Department (ED) visit summary dated 08/20/24 revealed:
-Resident #1 was seen in the ED on 08/20/24 for abdominal pain and fatigue.
-Resident #1's diagnoses included diarrhea.
-There was an order for dicyclomine (a medication to treat spasms in the bowels) 20mg, one tablet twice daily for five days.

Review of Resident #1's hospital discharge summary dated 08/28/24 revealed Resident #1 was admitted for near syncope (the feeling of being about to faint).

Review of Resident #1's August 2024 electronic Medication Administration Record (eMAR) revealed:
-There was an entry dated 08/22/24 for dicyclomine 20mg, one tablet twice daily at 8:00am and 8:00pm.
-Dicyclomine 20mg, one tablet was documented as administered on 08/22/24 at 8:00pm and on 08/25/24 at 8:00am.

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-Dicyclomine 20mg, one tablet was documented as not administered on 08/23/24 at 8:00am and 8:00pm and on 08/24/24 at 8:00am and 8:00pm due to "waiting on rx from pharmacy".
-Dicyclomine 20mg, one tablet was documented as not administered from 08/25/24 at 8:00pm to 08/27/24 at 8:00pm due to Resident #1 being hospitalized.

Interview with Resident #1 on 09/17/24 at 9:45am revealed:
-She was hospitalized for three days a few weeks ago.
-She was admitted for diarrhea and received intravenous (IV) fluids.

Observation of Resident #1's medications on hand on 09/19/24 at 10:09am revealed:
-There was a bubble pack containing dicyclomine 20mg for Resident #1.
-The dicyclomine 20mg bubble pack was in the PRN (as needed) section of the medication cart.
-The pharmacy label indicated dicyclomine 20mg, 10 tablets were dispensed for Resident #1 on 08/21/24.
-The pharmacy label indicated Resident #1 was to be administered dicyclomine 20mg, one tablet twice daily for five days.
-There were seven dicyclomine 20mg tablets remaining in the bubble pack.

Interview with the medication aide (MA) on 09/19/24 at 10:14am revealed:
-Each resident had a designated area in the medication cart for their medications that were scheduled.
-All residents' PRN medications were kept together in another location in the medication cart.
-Resident #1's scheduled dicyclomine 20mg was

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placed in the PRN area of the medication cart when it should have been placed in Resident #1's designated area of the medication cart.
-If a resident's scheduled medication was not in their designated area of the medication cart, the MA should have checked the PRN area for the medication.
-The MA should also check the entire medication cart because resident medications could be misplaced in another resident's area of the medication cart or even in another medication cart.
-After checking all medication carts, if a medication still could not be located to administer, the MA was responsible to ensure the medication order was still active and call the pharmacy.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/19/24 at 8:56am and 12:53 revealed:
-Dicyclomine 20mg, ten tablets were dispensed for Resident #1 on 08/21/24.
-If Resident #1 did not receive dicyclomine 20mg as ordered she could experience stomach cramping, diarrhea and possible dehydration.

Interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:05am revealed:
-The MAs were responsible to administer resident medications as ordered.
-If a medication was not located in the resident's medications, the MA was to check all areas of all medication carts.
-If a medication still was not located, the MA was to call the pharmacy and notify the RCC.
-The RCC was responsible to review the missed medications report weekly for missed medications.
-She was unsure if Resident #1's dicyclomine 20mg was on the missed medications weekly

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MINT HILL SENIOR LIVING	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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
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report because she was not the RCC at that time.

Interview with the Administrator on 09/19/24 at 11:56am revealed:
-If a MA was not able find a resident's medication, the MA was to check all areas of all medication carts.
-If the medication was not located, the MA was to have a second person check all medication carts.
-The MA was to call the pharmacy and notify the RCC after a medication could not be located.
-The RCC was responsible to run a missed medication report daily.
-Corporate staff ran a missed medication report weekly and the RCC was responsible for following up on any missed medications.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 09/19/24 at 12:50pm was unsuccessful.

2. Review of Resident #3's FL-2 dated 02/09/24 revealed diagnosis included hypertension, bipolar disorder and anxiety disorder.

Review of Resident #3's Primary Care Providers (PCP) orders dated 08/28/24 revealed there was an order for amlodipine (a medication to treat high blood pressure) 2.5mg, take 1 tablet daily. Hold for systolic blood pressure (SBP) less than 110 or diastolic blood pressure (DBP) less than 60.

Review for Resident #3's July 2024 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for amlodipine 2.5mg, take 1 tablet once daily, hold for SBP less than 110 or DBP less than 60. Scheduled at 8:00am.
-There was no field to document Resident #3's

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blood pressure.
-Amlodipine was documented as administered from 07/01/24 through 07/31/24 at 8:00am without checking Resident #3's blood pressure prior to administration at 8:00am.

Review of Resident #3's vital report revealed:
-Resident #3's blood pressure was taken on 07/02/24 at 11:36am with a reading of 154/75.

Review for Resident #3's August 2024 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for amlodipine 2.5mg, take 1 tablet once daily, hold for SBP less than 110 or DBP less than 60. Scheduled at 8:00am.
-There was no field to document Resident #3's blood pressure.
-Amlodipine was documented as administered from 08/01/24 through 08/31/24 at 8:00am without checking Resident #3's blood pressure prior to administration at 8:00am.

Review of Resident #3's vital report revealed:
-Resident #3's blood pressure was taken on 08/02/24 at 08:57am with a reading of 110/63.
-Resident #3's blood pressure was taken on 08/06/24 at 08:59am after a fall with a reading of 134/84.

Review for Resident #3's September 2024 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for amlodipine 2.5mg, take 1 tablet once daily, hold for SBP less than 110 or DBP less than 60. Scheduled at 8:00am.
-There was no field to document Resident #3's blood pressure.
-Amlodipine was documented as administered from 09/01/24 through 09/18/24 at 8:00am

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without checking Resident #3's blood pressure prior to administration at 8:00am.

Review of Resident #3's vital report revealed:
-Resident #3's blood pressure was taken on 09/02/24 at 1:44pm with a reading of 149/87.

Interview with a medication aide (MA) on 09/18/24 at 10:00am revealed:
-She kept a notebook with resident's blood pressures that required documenting on the eMar.
-Resident #3 did not have a field on the eMar to document blood pressures.
-She did not take Resident #3's blood pressure prior to administering the amlodipine.
-She had not told anyone that there was no field to document Resident #3's blood pressure because it had slipped her mind.

Interview with the Residential Care Coordinator (RCC) on 09/18/24 at 10:15am revealed:
-There should have been a field on the eMar to document Resident #3's blood pressure.
-The RCC or the Administrator should have verified the order and should have clicked on the task to add the blood pressure on the eMar.
-Resident #3 should not have received her amlodipine without checking the blood pressure first.
-She had begun doing chart audits at the beginning of September 2024 and was completing them alphabetically and had not yet gotten to Resident #3's name.

Interview with the Nurse Practitioner (NP) on 09/18/24 at 11:20am revealed:
-She expected the blood pressure to be checked prior to administering the amlodipine.
- If Resident #3 was administered amlodipine

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D 358	Continued From page 17 when her blood pressure was low, could have resulted in dizziness, weakness, fainting and being clammy. -Resident #3's blood pressures were usually stable. -She had not reviewed Resident #3's blood pressure for the last three months. Interview with the Pharmacist from the facility's contracted pharmacy on 09/19/24 at 9:09am revealed: -The parameters for the medication are added to the eMar by the pharmacist. -The facility was responsible to enter the field for the blood pressure on the eMar. -If Resident #3 was administered amlodipine when her blood pressure was low could have resulted in a drop in blood pressure fainting, and shortness of breath. Interview with the Administrator on 09/19/24 at 11:56am revealed: -The RCC should have reviewed the eMar to ensure the blood pressure field was added in. -The MA should have reviewed the parameters on the eMar and if an omission or error is noticed they should notify the RCC. -It was her expectation that medications are always administered accurately.	D 358		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.	D 406		

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This Rule is not met as evidenced by:
Based on interviews and record review, the facility failed to follow up on a pharmacy review recommendation for 3 of 5 sampled residents (#1, #2 and #4).

The findings are:

Review of the facility's Pharmaceutical Care policy dated September 2021 revealed the facility shall assure action is taken as needed in response to the medication review and the response is documented.

1. Review of Resident #1's current FL2 dated 02/07/24 revealed diagnoses included hypertension, lupus (disease that causes the immune system to attack healthy tissue and cells), and arthritis.

Review of Resident #1's Primary Care Provider's (PCP) orders dated 08/28/24 revealed an order for alendronate (a medication to treat and prevent thinning of bones) 70mg, one tablet weekly on Mondays.

Review of Resident #1's quarterly pharmacy drug review dated 07/18/24 revealed:
-There were recommendations to avoid potential medication administration errors and/or medication ineffectiveness.
-It was recommended alendronate 70mg was to be swallowed whole with eight ounces of water at least 30 minutes prior to the first food, beverage, or medication of the day.
-It was recommended the resident should not lie down for at least 30 minutes and until their first

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food of the day.
-It was recommended the parameters be included in the order for alendronate 70mg and the administration time be changed to 6:00am.
-There was no response indicated to the recommendations.

Interview with Resident #1's PCP on 09/18/24 at 11:05am revealed:
-She had not seen Resident #1' pharmaceutical review dated 07/18/24.
-She would have accepted the pharmacist's recommendations if she had been aware of them.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:05am.

Refer to the interview with the Administrator on 09/19/24 at 11:56am.

Attempted telephone interview with the facility's contracted Pharmacist on 09/19/24 at 10:41am was unsuccessful.

2. Review of Resident #2's current FL2 dated 11/10/23 revealed:
-Diagnoses included anemia, asthma, and diabetes.
-Resident was non-ambulatory
-There was no information on the FL2 for Resident #2's disorientation.

Review of Resident #2's Resident Register dated 11/01/23 revealed resident was admitted on 11/01/23.

Review of Resident #2's Care Plan dated 03/04/24 revealed:
-Resident #2 was independent with eating, toileting, ambulation and transfers.

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-Resident #2 needed assistance with bathing and grooming.

Review of Resident #2's quarterly pharmacy drug review dated 07/17/24 revealed:
-There was a recommendation for medications used whenever needed (prn) to add a clear indication as to why the medication was to be used.
-There was a recommendation to add to the order for Advair HFA: rinse mouth with water and spit after use.
-There was no response indicated on the recommendations.

Interview with Resident #2's PCP on 09/18/24 at 11:05am revealed:
-She had not seen Resident #2's pharmaceutical review dated 07/17/24.
-She would have accepted the pharmacist's recommendations if she had been aware of them.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:05am.

Refer to the interview with the Administrator on 09/19/24 at 11:56am.

Attempted telephone interview with the facility's contracted Pharmacist on 09/19/24 at 10:41am was unsuccessful.

3. Review of Resident #4's current FL2 dated 10/05/23 revealed:
-Diagnoses included chronic obstructive pulmonary disease, morbid obesity, schizoaffective disorder, generalized anxiety, and functional urinary incontinence.

Review of Resident #4's pharmacy prescription

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dated 02/15/24 revealed there was an order for miconazole nitrate powder 2% over the counter (OTC) apply to affected area(s) topically twice daily.

Review of a pharmacy medication issued report for Resident #4 dated 07/17/24 revealed that the pharmacist recommended the order for antifungal powder 2% with directions to apply to the affected area should be specific to avoid confusion or discontinued if no longer needed.

Review of a physician's order for Resident #4 dated 08/28/24 revealed there was an order for Antifungal miconazole nitrate 2% over the counter (OTC) apply topically to affected area(s) twice daily.

Review of Resident #4's September 2024 electronic medication administration record (eMAR) revealed Antifungal miconazole nitrate 2% over the counter (OTC) apply topically to affected area(s) twice daily.

Interview with the Administrator on 09/19/24 at 11:56am revealed:
-The pharmacy review for Resident #4 dated 07/17/24 was uploaded into the facility's computer-based tracking system by previous management staff as though the pharmacy review had been completed.
-There was no follow-up on Resident #4's pharmacy recommendations.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:05am.

Refer to the interview with the Administrator on 09/19/24 at 11:56am.

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D 406	Continued From page 22 Attempted telephone interview with the facility's contracted Pharmacist on 09/19/24 at 10:41am was unsuccessful. _____ Interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:06am revealed: -The RCC was responsible to review the pharmacy review reports when they were received and follow-up on any recommendations. -The RCC sent the pharmacy report to the resident's physician to review and determine any changes based on the Pharmacist's recommendations. -The RCC would send the pharmacy report to the pharmacy to add any recommendations approved by the physician to the resident's eMAR. Interview with the Administrator on 09/19/24 at 11:56am revealed: -The reviewing pharmacist provided the RCC with a list of pharmacy recommendations. -The RCC was responsible for sending the list to the prescribing provider to clarify the pharmacist's recommendations. -Once clarified by the prescribing provider, the pharmacy recommendations were sent to the pharmacy to upload onto the eMAR. -She was not aware the previous RCC had not followed-up on the pharmacy review reports.	D 406		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a	D 451		

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resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services (DSS) for incidents involving 5 of 5 sampled residents (Resident #1, #2, #3, #4 and #5) who received injuries that required emergency medical treatment.

The findings are:

Review of the facility's undated Accident or Incident policy revealed if an incident requires intervention greater than first aid, the accident and incident report form should be sent to the local county Department of Social Services within 48 hours.

1. Review of Resident #1's current FL2 dated 07/07/24 revealed diagnoses included major depressive disorder, hypertension, dementia, hypokalemia (low potassium level), asthma, lupus (disease that causes the immune system to attack healthy tissue and cells), and arthritis.

Review of Resident #1's resident register revealed an admission date of 12/19/19.

Review of Resident #1's hospital discharge summary dated 08/28/24 revealed:
-Resident #1 was admitted to the hospital from 08/25/24 to 08/28/24.
-Resident #1 was admitted for near syncope (the feeling of being about to faint).

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D 451	Continued From page 24 Interview with Resident #1 on 09/17/24 at 9:45am revealed: -She was hospitalized for three days a few weeks ago. -She was admitted for diarrhea and received intravenous (IV) fluids. Interview with the Administrator on 09/18/24 at 12:25pm revealed there was no incident report completed when Resident #1 was sent to the hospital on 08/25/24. Interview with the Adult Home Specialist (AHS) on 09/19/24 at 10:14am revealed she had not received an incident report for Resident #1's hospital admission on 08/25/24. Refer to the interview with the Adult Home Specialist (AHS) on 09/19/24 at 10:14am. Refer to the interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:06am. Refer to the interview with the Administrator on 09/19/24 at 11:56am. 2. Review of Resident #2's current FL2 dated 11/10/23 revealed: -Diagnoses included anemia, asthma, and diabetes. -Resident was non-ambulatory -There was no information on the FL2 for Resident #2's disorientation. Review of Resident #2's Resident Register dated 11/01/23 revealed: -Resident #2 was admitted on 11/01/23. Review of Resident #2's Care Plan dated 03/04/24 revealed:	D 451		

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-Resident #2 was independent with eating, toileting, ambulation and transfers.
-Resident #2 needed assistance with bathing and grooming.

Review of Resident #2's Incident and Accident report on 07/02/24 revealed:
-Resident #2 was sent to the emergency department (ED) on 07/02/24 at 8:47am for left sided hip pain.
-Resident #2's primary care provider (PCP) was notified on 07/02/24 at 8:48am.
-Resident #2's family representative was notified on 07/02/24 at 8:48am.
-The facility did not submit an Incident and Accident report to DSS.

Interview with the Adult Home Specialist (AHS) on 09/19/24 at 10:14am revealed she had not received an incident report for Resident #2's ED visit on 07/02/24.

Refer to the interview with the Adult Home Specialist (AHS) on 09/19/24 at 10:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:06am.

Refer to the interview with the Administrator on 09/19/24 at 11:56am.

3. Review of Resident #5's current FL2 dated 05/02/24 revealed:
-Diagnoses included hemiparesis of the right side (partial weakness or an ability to move on the right side of the body), hypertension, chronic kidney disease and controlled diabetes.
-Resident was semi-ambulatory and used a wheelchair.
-Resident was oriented.

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D 451	Continued From page 26 Review of Resident #5's Resident Register revealed he was admitted on 12/22/20. Review of Resident #5's Care Plan dated 02/28/24 revealed: -Resident #5 was independent for ambulation and transfers. -Resident #5 needed limited assistance for eating, toileting, bathing, dressing and grooming. Review of Resident #5's Incident and accident reports revealed: -Resident #5 was sent to the ED on 07/20/24 at 1:20pm for hallucinations and disorientation. -The facility did not submit an Incident and Accident report to DSS. -Resident #5 was sent to the ED on 09/04/24 at 12:12pm for an unwitnessed fall. -The facility did not submit an Incident and Accident report to DSS. -Resident #5 was sent to the ED on 09/06/24 at 10:24am for severe pain in knee. -The facility did not submit an Incident and Accident report to DSS. Interview with the Adult Home Specialist (AHS) on 09/19/24 at 10:14am revealed she had not received incident reports for Resident #5's ED visits on 07/20/24, 09/04/24 and 09/06/24. Refer to the interview with the Adult Home Specialist (AHS) on 09/19/24 at 10:14am. Refer to the interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:06am. Refer to the interview with the Administrator on 09/19/24 at 11:56am.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINT HILL SENIOR LIVING	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 451	Continued From page 27	D 451		

4. Review of Resident #3's FL-2 dated 02/09/24 revealed diagnosis included hypertension, bipolar disorder and anxiety disorder.

Review of Resident #3's resident register revealed an admission date of 12/21/23.

Review of an Accident/Incident report dated 08/06/24 revealed Resident #3 had fallen in her bathroom on 08/06/24 at 8:45am which required a transfer to the Emergency room (ER).

Review of Resident #3's ER after visit summary dated 08/06/24 revealed
-Resident #3 was seen for a fall, and unspecified headache.
-Resident #3 was returned back to the facility on the same day (08/06/24).

An interview with the Adult Home Specialist on 09/19/24 at 10:45am revealed she had not received a accident report for Resident #3 dated 08/06/24.

Refer to the interview with the Adult Home Specialist (AHS) on 09/19/24 at 10:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:06am.

Refer to the interview with the Administrator on 09/19/24 at 11:56am.

5. Review of Resident #4's current FL2 dated 10/05/23 revealed diagnoses included chronic obstructive pulmonary disease, morbid obesity, schizoaffective disorder, generalized anxiety, and functional urinary incontinence.

Review of Resident #4's Accident and Incident

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D 451	Continued From page 28	D 451		

Report dated 07/25/24 revealed:
-Resident #4 had a medical observation of choking and was unable to breathe which required a visit to the emergency department (ED).
-There was no documentation that DSS was notified of the incident.

Review of Resident #4's Accident and Incident Report dated 08/07/24 revealed:
-Resident #4 had a medical observation of being found lying on the floor which required a visit to the emergency department (ED).
-There was no documentation that DSS was notified of the incident.

Review of Resident #4's Accident and Incident Report dated 08/15/24 revealed:
-Resident #4 had a medical observation of not being able to walk and was very shaky which required a visit to the emergency department (ED).
-There was no documentation that DSS was notified of the incident.

Refer to the interview with the Adult Home Specialist (AHS) on 09/19/24 at 10:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:06am.

Refer to the interview with the Administrator on 09/19/24 at 11:56am.

_____

Interview with the AHS on 09/19/24 at 10:14am revealed:
-The AHS pulled the last three months of Incident and Accident reports from the facility.
-There was only one report sent from the facility for July 2024, August 2024 and September 2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	09/19/2024

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D 451	Continued From page 29 -The facility was responsible to fax Incident and Accident reports to the county Department of Social Services (DSS) within 48 hours of the incident or accident. Interview with the Resident Care Coordinator (RCC) on 09/19/24 at 11:06am revealed: -Medication Aides (MAs) were responsible for completing Accident and Incident reports. -The RCC and Administrator were responsible for reviewing and completing Accident and Incident reports within 24-48 hours. -Accident and Incident reports that were sent to DSS included falls with injury, resident behaviors, and 24 hour/5 day reports. -The RCC and the Administrator were responsible for sending Accident and Incident reports to DSS. Interview with the Administrator on 09/19/24 at 11:56am revealed: -The Administrator was not aware that Accident and Incident reports were not being sent to DSS. -Medication Aides (MAs) were responsible for completing Accident and Incident reports. -Accident and Incident reports that involved medical treatment beyond first aide should be sent to DSS. -The RCC was responsible for reviewing and ensuring that accident and incident reports were completed and faxed to DSS within 24-48 hours of an incident.	D 451		