STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 000	Initial Comments The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted a COVID-19 focused infection control survey and a complaint investigation with an onsite visit on 09/15/20 to 09/16/20, 09/18/20, and 09/21/20 to 09/22/20, with a desk review survey on 09/17/20 and 09/23/20 to 09/30/20, with an exit conference via telephone on 09/30/20. The complaint investigation was initiated by the Cabarrus County Department of Social Services on 07/15/20.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure walls, ceilings, and floors or floor coverings were kept clean and in good repair in several resident rooms, one hallway, and 2 of 3 common shower/bathrooms. The findings are: Observation of the common bathroom area on the first floor on 09/15/20 at 9:08am revealed: -The bathroom floor was dirty and smeared with a	D 074		

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D 074	Continued From page 1	D 074		

blackish brown substance.
-The trash was piled up in the trash can and overflowing onto the floor.
-There were dirty towels and wash cloths lying on the bathroom floor.
-There was toilet paper with feces on it laying on the floor near the toilet.

Observation of a resident's room on the first floor on 09/15/20 at 11:02am revealed:
-There was a dark sticky substance on the floor.
-There were food crumbs and trash on the floor.

Observation of resident room #217 and #218 on 09/18/20 from 8:39am to 12:15pm revealed:
-There was dirt, crumbs and debris on the floors.
-There was a grayish substance on the white tile floor in room #218.
-There was a resident in room #217 lying on the bed, her feet were dirty with a grayish black substance.

Observation of the second floor common shower room on 09/18/20 at 9:19am revealed:
-The room was in disarray including empty soap bottles along the edge of the tub, and under the shower chair.
-There was a box of incontinent briefs sitting on top of the bathtub.
-There were resident's clothes hanging from the top railing.
-There was a basket of residents' clothes unfolded sitting on top of the supply cart.
-There were mismatched shoes under the sink and supply cart.
-The room had a musty odor.
-There was a bag of soiled linen under the sink.

Observation of the bathroom in Room #307 on 09/15/20 at 9:13am revealed a full trash can and

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 074	Continued From page 2	D 074		

debris on the tile floor.

Observation of a third floor hallway on 09/15/20 at 9:36am revealed:
-The side hallway next to the shower had bags of dirty clothes and soiled bed linens piled up in a corner.
-There were flies flying around the bags of clothing and a strong urine odor.

Observation of a room on the third floor on 09/15/20 at 9:28am revealed:
-There were soiled bed linens in the doorway of the residents' room.
-The linens were visibly soiled with yellow stains and had a strong urine odor and were not in a bag.
-There was no staff present inside, outside, or near the resident's room.

Interview with the third floor medication aide (MA) on 09/15/20 at 9:30am and 9:38am revealed:
-She had not realized there was soiled linens in room 326.
-The linens "must have been from yesterday, we haven't changed linens yet".
-She agreed to move the soiled linens and place in a laundry bag.
-The bags in the hallway contained soiled linen and clothing from the residents.
-The washer and dryer on the third floor were broken and all clothing had to be transported to the first floor for washing/drying.
-The washer and dryer had been out for "a while".
-Residents were responsible for putting clothes outside of their door for staff to pick up.

Observation of the ceiling tiles in Room 322 on 09/18/20 at 9:03am revealed:
-The ceiling tiles in between the recessed lighting

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 074	Continued From page 3	D 074		

and the air conditioning (AC) unit were stained brown, and appeared to be wet.
-There were blue incontinent pads lying in the floor to absorb the water from the AC unit.

Observation of the facility on 09/18/20 from 9:00am to 11:00am revealed:
-There were no housekeepers cleaning or sanitizing the facility.
-There was a medication aide (MA) collecting trash out of the resident's rooms.
-There was no one sweeping the floors, sanitizing the building, or cleaning the resident's rooms.

Interview with a housekeeper on 09/17/20 at 11:00am revealed:
-She cleaned the toilets and bathrooms in the facility and in the resident rooms.
-She used sanitizer in the green bottle to clean the high touch areas.
-She did not go on the third floor to clean during the COVID-19 outbreak.

Interview with the Maintenance Director on 09/18/20 at 9:17am revealed:
-There were no housekeepers working in the building today.
-The one housekeeper that was supposed to work had called out.
-The facility usually had 3 staff cleaning the building, one for each floor, but they were not present.
-His primary responsibility was ensuring personal protective equipment (PPE) was available on each floor and then working on maintenance and repair concerns.
-All staff present were responsible for providing housekeeping duties which included sweeping, mopping, sanitizing rooms, hallways, and common areas.

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 074	Continued From page 4 Interview with a housekeeper on 1st floor on 09/21/20 at 9:40am revealed: -She worked in the facility as a housekeeper. -Her duties included cleaning the floors, resident rooms, and hallways. -She did not go on the third floor during the COVID-19 outbreak. -The personal care aides (PCAs) were responsible for cleaning the residents room and bathrooms. -The PCAs were responsible for emptying the trash. Interview with the Administrator on 09/16/20 at 11:00am revealed: -The third floor was designated as the COVID-19 floor during the outbreak. -Residents on the third floor were both COVID-19 positive and negative, the COVID-19 positive were placed on the back hallway. -She was not aware residents were cleaning there own rooms and bathroom during the COVID-19 outbreak in the facility. -She was aware that 2 of the 3 housekeepers and the Maintainance Director did not go to the third floor during the COVID-19 outbreak. Interview with the Administrator on 09/21/20 at 10:32am revealed: -She was responsible for the day to day operations of the facility. -Everyone was responsible for housekeeping. -The third floor was the independent floor. -The residents on the 3rd floor wanted to clean for themselves. -The staff on third floor does not expect residents to clean toilets. Review of the facility's COVID-19 policy on	D 074		

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 074	Continued From page 5 cleaning the community revealed: -The disinfectant that was utilized by the facility was certified to kill COVID-19. -Staff would spray down surfaces that were touched frequently: door handles, hand rails, commodes, sinks, and counter tops on each shift. -The maintenance team would spray surfaces in each community every week with the certified disinfectant using a mechanical sprayer. -Management of laundry and medical waste would be performed in accordance with the assisted living community's procedures.	D 074		
D 119	0A NCAC 13F .0311(j) Other Requirements 10A NCAC 13F .0311 Other Requirements (j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This rule applies to new and existing facilites. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to provide 2 residents on the third floor with call bells for (Resident #7 and Resident #18). The findings are: Observation on 9/18/20 at 9:28am revealed: -There was a total of 35 residents on the 3rd floor which was designed as the COVID-19 postive floor. -There was a list labeled "3rd floor call bells" taped to the wall at the nurses desk with 9	D 119		

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 119	Continued From page 6	D 119		

resident names who had pendants.
-There was a monitor for the pendants at the nurses desk that was in working condition.

1. Review of Resident #7's current FL2 dated 04/30/20 revealed:
-Diagnoses included pelvic fracture, chronic obstructive pulmonary disease, and vascular dementia.
-The resident was semi-ambulatory.

Review of Resident #7's Care Plan dated 01/14/20 revealed the resident required limited assistance with ambulation.

Review of Resident 7's "care notes" revealed:
-A note on 08/31/20 at 7:49 (the time of day was not documented) indicating Resident #7 had an unwitnessed fall.
-It was documented the resident hit his head and had bleeding on both arms.
-The provider was notified and the resident was sent to the emergency room for further evaluation.

Review of a "falls investigation summary" for Resident #7 dated 09/01/20 revealed:
-Resident #7 was found on the floor in his bedroom at 5:04am.
-The fall was unwitnessed by staff.
-There were no injuries documented.

Observation of Resident #7 on 09/15/20 at 11:35am revealed :
-Resident #7 resided on the 3rd floor.
-There was no call bell available for the resident to use.

Interview with the contracted physical therapist on 09/17/20 at 4:01pm revealed:

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 119	Continued From page 7	D 119		

-Physical therapy (PT) was initiated for Resident #7 after a recent hospitalization on 09/11/20.
-Resident #7 was assessed as maximum assistance with transfers and a one person assist with his walker.
-She educated staff on his needs on 09/14/20.
-She had to assist him to a standing position, she had to pull up his pants and lower him back to chair.
-Resident #7 would require assistance getting out of the facility in case of an emergency.

Refer to interview with a medication aide (MA) on 09/18/20 at 8:45am.

Refer to interview with a MA/Floor Supervisor on 09/18/20 at 8:53am.

Refer to interview with the Administrator on 09/18/20 at 10:37am.

Refer to interview with a first shift MA on 9/18/20 at 8:35am.

_____

2. Review on Resident #18 s' current FL2 dated 02/19/20 revealed:
-Diagnoses included atrial fibrillation, anxiety and history of cerebral vascular accident (CVA).
-Resident #18 as semi-ambulatory using a walker.

Interview with Resident #18 on 09/15/20 at 9:15 revealed:
-She resided on the third floor.
-She did not have a call bell in her room so at night she would get up to find staff when she needs help.
-Sometimes she got scared due to her heart history.
-She found staff sleeping at night in the common

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 119	Continued From page 8 area living room. -"Staff do not check on you at night." Observation of Resident #18 on 09/15/20 between 10:05am and 11:00am revealed she required a walker for ambulation to the first floor smoking area. Observation of Resident #18's room on 09/16/20 at 2:47pm revealed she had a small bell on her bedside table near the bed. Refer to interview with a medication aide (MA) on 09/18/20 at 8:45am. Refer to interview with a MA/Floor Supervisor on 09/18/20 at 8:53am. Refer to interview with the Administrator on 09/18/20 at 10:37am. Refer to interview with a first shift MA on 9/18/20 at 8:35am. _____ Interview with a medication aide (MA) on 09/18/20 at 8:45am revealed: -All of the residents in the facility did not have a call bell. -Only residents who required additional assistance had a call bell. -MAs and PCAs were responsible for completing rounds every 2 hours to check on residents. -In between every 2-hour checks, residents would have to come find her if they needed assistance. -There were only 3 residents on the first floor who had call bells. Interview with a MA/Floor Supervisor on 09/18/20 at 8:53am revealed:	D 119		

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 119	Continued From page 9 -Call bells were provided to residents who were more "fragile" and required more care. -Residents who were on hospice and needed more care had a call bell around their neck or attached to their bed. - "We complete rounds every 2 hours to check on everyone". -Resident's could find staff if they needed assistance. Interview with the Administrator on 09/18/20 at 10:37am revealed: -There was a call bell system on each floor. -Most residents had a call bell or a cowbell to alert staff if they need assistance. -Residents that did not have a call bell or cowbell could use their cellphones to call the facility if they needed assistance. -There was no extra cost for a pendant and if anyone needed a call bell it was available. -She did not know everyone in the facility did not have a call bell or cowbell. Interview with a first shift MA on 9/18/20 at 8:35am revealed: -All residents on the third floor have a pendant if they are a fall risk or they requested to have one. -The residents that do not have one are independent and do not need one.	D 119		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for	D 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 188	Continued From page 10	D 188		

a home with a census of 13-20 shall apply.
(1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least:
(A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)
(D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.
(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews and record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 188	Continued From page 11	D 188		

reviews, the facility failed to ensure the minimum number of staff were always present to meet the needs of residents on 20 of 39 shifts sampled for 13 days between 09/02/20 and 09/14/20, which resulted in a lack of adequate staff required to provide personal care such as bathing, toileting, catheter care, skin care, dressing assistance, feeding assistance and grooming.

The finding are:

Review of NCDHHS Emergency Staffing Recommendations during the COVID-19 pandemic revealed:
-Staff who test positive for COVID-19 will be unable to work until they meet the criteria for returning to work. This can cause sudden staffing shortages at a time when extra work is required to control the outbreak.
-Facilities should prepare for the possibility of staffing shortages and have a concrete plan with specific steps to take if they do need additional staff.
-The following options should be considered for emergency staffing:
-Allowing caregivers that are positive but asymptomatic to staff areas dedicated to caring for positive residents (while wearing appropriate PPE).
-Contacting temporary staffing agencies.
-Contacting other sister agencies for temporary staffing support.
-Contacting local hospitals for temporary staffing support.
-If all these options have been exhausted and additional staffing is still needed, your local health department can request emergency staff from the state.
-Emergency staffing requests typically take several days to fill.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 188	Continued From page 12	D 188		

-Facilities should begin searching for additional staff as soon as staff are tested rather than waiting for test results to come back, so these emergency staffing requests can be filled if necessary.

Review of the facility's 2020 license from the Division of Health Service Regulation revealed the facility was licensed as an Assisted Living with a capacity of 180 beds.

1. Review of Resident #2's current FL2 dated 05/01/20 revealed:
-Diagnoses included atrial fibrillation, congestive heart failure, urinary retention, degenerative joint disease and depression.
-Resident #2 was semi-ambulatory with assistance of a rollator.
-Resident #2 had a suprapubic catheter.

Observation of Resident #2 on 09/15/20 at 11:31am revealed:
-During the initial tour of the facility on the third floor, Resident #2 was observed in her bed with a full catheter bag on the floor under her bed.
-Resident #2 had an incontinent brief on and the catheter tubing was twisted around the brief and her legs.
-There were indentations on her skin where she had laid on the tubing.
-The incontinent brief had a small amount of fecal matter inside and on the catheter tubing.
-The area between Resident #2's buttocks were chafed, red and irritated.
-There was skin breakdown inside the vaginal folds and thick mucus in the vaginal opening.
-The site around the opening of the suprapubic catheter opening in the abdominal area was red and tender.

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 188	Continued From page 13	D 188		

Observation of Resident #2 on 09/16/20 at 7:45am revealed:
-Resident #2 was in her bed with her eyes closed.
-Resident #2's catheter bag was full to capacity with urine and lying under her bed on the floor.
-Resident#2 was in the same bathrobe she had on yesterday with some food stains on the front.
-Resident #2's hair was greasy and matted.
-Resident #2's incontinent brief was soaked with light colored liquid, possibly urine.

Telephone interview with Resident #2 on 09/24/20 at 11:44am revealed:
-She used to empty her own catheter bag, however she needed the staff to assist now.
-Sometimes she woke up and the bag was full of urine.
-Some staff told her they did not know how to empty the catheter bag and some staff said it was her responsibility.
-Since she had been ill, she needed assistance walking and taking a shower.
-She had been asking for a shower for a long time.

Telephone interview with Resident #2's responsible family member on 09/18/20 at 2:32pm revealed:
-She relayed to the Administrator Resident #2 needed more assistance from the staff with her personal care and her catheter care.
-Some of the staff say they do not know how to empty the catheter and some of the staff say it was Resident #2's responsibility.
-Resident #2 also needed more cueing and prompting for daily tasks.
-When she finally spoke with Resident #2, she said the staff had not been providing her personal care.
-She had not had a shower or hair washed and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 188	Continued From page 14 no help with her catheter. 2. Review of Resident #7's current FL2 dated 04/30/20 revealed: -Diagnoses included pelvic fracture, chronic obstructive pulmonary disease, and vascular dementia. -Bathing and dressing were checked as personal care tasks in which the resident required assistance. -The resident was semi-ambulatory. -The resident was continent with bowel and bladder. Review of Resident #7's Care Plan dated 01/14/20 revealed: -The resident required extensive assistance with bathing and dressing. -The resident required limited assistance with grooming. Observation of Resident #7 on 09/15/20 at 11:35am revealed: -Resident #7 was sitting in his room in a chair across from his television. -He was disheveled, his jeans were positioned below waist sitting at thigh level exposing an incontinent brief. -The resident had on a grey shirt with food stains on the front. -His hair was matted and greasy and he was unshaved. -The resident appeared to not have had a shower. Observation of Resident #7 on 09/16/20 at 10:00am revealed: -The resident still had on the grey shirt with food stains on the front. -His hair was still matted, greasy, and he was	D 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 188	Continued From page 15	D 188		

unshaved.
-The resident still appeared to not have had a shower.

Observation of Resident #7 on 09/21/20 at 3:22pm revealed:
-The resident was lying in his bed resting.
-The resident's room smelled of a stale bowel movement.

Based on observations, interviews and record review it was determined Resident #7 was not interviewable.

3. Review of Resident #9's current FL2 dated 03/03/20 revealed:
-Diagnoses included dementia, diabetes, hypertension and anxiety.
-Resident #9 was ambulatory and incontinent of bowel and bladder.
-Resident #9's skin was normal.

Review of Resident #9's care plan dated 05/09/20 revealed:
-Resident #9 was ambulatory with the use of a walker.
-Her skin was normal.
-Her speech was normal.
-Resident #9's activities of daily living were (4) totally dependent for bathing and dressing.

Review of Resident #9's physical therapy (PT) notes dated 08/31/20 revealed:
-Resident #9 was found in her room sitting in the chair; lethargic and required physical assistance to awaken.
-"There were no care staff on the floor."
-PT assisted Resident #9 with eating, "food tray was not touched."
-Required max- assistance to keep Resident #9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 188	Continued From page 16 awake. Telephone interview with Resident #9's Home Health (HH) nurse on 09/17/20 at 11:35am revealed: -She was in the facility daily seeing residents. -She found Resident #9 with saturated incontinent briefs and the smell of urine multiple times when she performed care. Based on observations, interviews and record review it was determined Resident #9 was not interviewable. 4. Review of Resident #17's most recent FL2 dated 08/21/19 revealed: -Diagnosis included diabetes, bipolar disorder, and hypertension. -The resident was ambulatory. -She was incontinent with bladder and bowel. -The resident required assistance with bathing and dressing. Review of Resident #17's Care Plan dated 01/07/20 revealed: -The resident required extensive assistance with bathing and dressing. -The resident required limited assistance with grooming and personal hygiene. Observation of Resident #17 on 09/15/20 at 12:15pm revealed: -The resident was lying on her bed watching television with the back of her feet facing the floor. -The resident's feet were dirty, layered with a grayish black dirt substance. - The resident was disheveled and her hair was greasy.	D 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 188	Continued From page 17 Interview with Resident #17 on 09/15/20 at 12:15pm revealed: -She could not remember the last time she had a shower. -She had not changed clothes since waking up on 09/15/20. -She could not remember the last time she changed her clothes. -The staff had not assisted her with completing showers or grooming. -She did not know when her shower days were scheduled. Review of the facility's COVID-19 policy on staffing of the community during a pandemic revealed: -A contingency staffing plan will be developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential community operations. -Each assisted living community will staff to meet the minimum requirements set by DHHS as long as possible. -Each assisted living community will review and understand their staffing needs and the minimum number of staff needed to provide a safe work environment and resident care. -Each assisted living community will hire additional healthcare personnel when possible. -Each assisted living community will be in communication with local healthcare coalitions, federal, state and local public health partners to identify additional healthcare personnel when needed. -Each assisted living community will cancel all non-essential procedures and visits. -Each assisted living community will adjust staff schedules to move staff in non-essential roles to	D 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 188	Continued From page 18	D 188		

positions that support resident care activities.
-Each assisted living community will ensure that staff moved into positions to support resident care activities will receive appropriate orientation and training to work in areas that are new to them.
-Each assisted living community will request that health care personnel postpone elective time off from work.
-Each assisted living community will enlist the assistance of staffing agencies to provide healthcare personnel.
-As a last resort, the community will contact churches and local civic groups to recruit volunteers to assist with staffing.

Review of the Resident Census Report dated 09/02/20 revealed there was a census of 111 residents which required 56 aide hours on second shift.

Review of the Employee Time Detail dated 09/02/20 revealed:
-There were 50.50 total staff hours provided on second shift.
-There was a shortage of 5.5 aide hours on second shift.

Review of the Resident Census Report dated 09/03/20 revealed there was a census of 111 residents which required 56 staff hours on second shift.

Review of the Employee Time Detail dated 09/03/20 revealed:
-There were 46.75 total staff hours provided on second shift.
-There was a shortage of 9.25 aide hours on second shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 188	Continued From page 19 Review of the Resident Census Report dated 09/04/20 revealed: -There was a census of 111 residents which required 56 staff hours on second shift. -There was a census of 111 residents which required 32 staff hours on third shift. Review of the Employee Time Detail dated 09/04/20 revealed: -There were 49.25 total staff hours provided on second shift. -There was a shortage of 2.75 aide hours on second shift. -There were 29 total staff hours provided on third shift. -There was a shortage of 3.0 aide hours on third shift. Review of the Resident Census Report dated 09/05/20 revealed: -There was a census of 111 residents which required 56 staff hours on first shift. -There was a census of 111 residents which required 56 staff hours on second shift. Review of the Employee Time Detail dated 09/05/20 revealed: -There were 54 total staff hours provided on first shift. -There was a shortage of 2.0 aide hours on first shift. -There were 43.5 total staff hours provided on second shift. -There was a shortage of 12.5 aide hours on second shift. Review of the Resident Census Report dated 09/06/20 revealed: -There was a census of 111 residents which required 56 staff hours on first shift.	D 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 188	Continued From page 20 -There was a census of 111 residents which required 56 staff hours on second shift. Review of the Employee Time Detail dated 09/06/20 revealed: -There were 44.75 total staff hours provided on first shift. -There was a shortage of 11.25 aide hours on first shift. -There were 43.75 total staff hours provided on second shift. -There was a shortage of 12.25 aide hours on second shift. Review of the Resident Census Report dated 09/07/20 revealed: -There was a census of 111 residents which required 56 staff hours on first shift. -There was a census of 111 residents which required 56 staff hours on second shift. Review of the Employee Time Detail dated 09/07/20 revealed: -There were 54.5 total staff hours provided on first shift. -There was a shortage of 1.5 aide hours on first shift. -There were 44 total staff hours provided on second shift. -There was a shortage of 12 aide hours on second shift. Review of the Resident Census Report dated 09/08/20 revealed there was a census of 109 residents which required 52 staff hours on second shift. Review of the Employee Time Detail dated 09/08/20 revealed: -There were 46 total staff hours provided on	D 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 188	Continued From page 21	D 188		

second shift.
-There was a shortage of 6 aide hours on second shift.

Review of the Resident Census Report dated 09/10/20 revealed:
-There was a census of 107 residents which required 52 staff hours on second shift.
-There was a census of 107 residents which required 32 staff hours on third shift.

Review of the Employee Time Detail dated 09/10/20 revealed:
-There were 41 total staff hours provided on second shift.
-There was a shortage of 11 aide hours on second shift.
-There were 26 total staff hours provided on third shift.
-There was a shortage of 6 aide hours on third shift.

Review of the Resident Census Report dated 09/11/20 revealed:
-There was a census of 107 residents which required 52 staff hours on first shift.
-There was a census of 107 residents which required 52 staff hours on second shift.
-There was a census of 107 residents which required 32 staff hours on third shift.

Review of the Employee Time Detail dated 09/11/20 revealed:
-There were 39 total staff hours provided on first shift.
-There was a shortage of 13 aide hours on first shift.
-There were 45.5 total staff hours provided on second shift.
-There was a shortage of 6.5 aide hours on

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 188	Continued From page 22	D 188		

second shift.
-There were 30 total staff hours provided on third shift.
-There was a shortage of 2 aide hours on third shift.

Review of the Resident Census Report dated 09/12/20 revealed there was a census of 107 residents which required 32 staff hours on third shift.

Review of the Employee Time Detail dated 09/12/20 revealed:
-There were 20 total staff hours provided on third shift.
-There was a shortage of 12 aide hours on third shift.

Review of the Resident Census Report dated 09/13/20 revealed there was a census of 107 residents which required 52 staff hours on second shift.

Review of the Employee Time Detail dated 09/13/20 revealed:
-There were 44.75 total staff hours provided on second shift.
-There was a shortage of 7.25 aide hours on second shift.

Review of the Resident Census Report dated 09/14/20 revealed:
-There was a census of 105 residents which required 52 staff hours on second shift.
-There was a census of 105 residents which required 32 staff hours on third shift.

Review of the Employee Time Detail dated 09/14/20 revealed:
-There were 48.25 total staff hours provided on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 188	Continued From page 23	D 188		

second shift.
-There was a shortage of 3.75 aide hours on second shift.
-There were 28.25 total staff hours provided on third shift.
-There was a shortage of 3.75 aide hours on third shift.

Interview with the Administrator on 09/21/20 at 2:58pm revealed:
-She was responsible for the staffing schedule.
-They were short staffed due to staff being afraid to work, had quit, or had tested positive for COVID-19.
-She and the Infection Control Manager (ICM) had filled in on occasion since the outbreak began in August, to provide direct care to residents.
-The Administrator had filled in once on 09/12/20, and the ICM daily from 09/02/20 to 09/14/20.
-She planned to hire more staff and was in the process of recruiting and interviewing new staff.
-The census had been between 101 and 110 since the outbreak began, and they have had no new admissions in the month of September.

Telephone interview with the Chief Operating Officer (COO) on 09/24/20 at 1:09pm revealed:
-She and the Administrator had reached out to several contract agencies on several occasions.
-The contract agencies did not have any staff to offer the facility or staff did not want to work in a COVID-19 positive facility.
-She was not aware the facility was short up to 13 hours per shift.
-On 09/22/20, she had contracted with a staffing agency to start helping out.
-The staffing agency was providing MAs and PCAs.
-The facility been actively interviewing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 188	Continued From page 24	D 188		

recruiting new staff.
-The facility tried to get help with staffing since the outbreak happened at the end of August.
-The Admininistrator was responsible for the staffing schedule.
-She had instructed the Administrator to reach out to the NC Emergency Management office when the outbreak began, but was not aware if she did.

Telephone interview with the ICM on 09/28/20 at 1:26pm revealed:
-She normally worked as the Marketing Director, but since the facility had an outbreak of COVID-19, she had been in charge of infection control for the facility.
-She received the facility's COVID-19 policy training on 04/14/20 and Donning and Doffing PPE training from the home health provider on 08/25/20
-"We always have enough staff to care for the residents."
-She was unaware that the facility was short staffed for the first 2 weeks in September.
-If they were short-staffed, they would call people in to work.
-The Administrator was responsible for the staffing schedule.

Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights.

Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision.

The facility failed to ensure the minimum number of staff were always present to meet the needs of residents, that required personal care assistance such as bathing, toileting, catheter care, skin care, dressing assistance, feeding assistance and grooming, residing in the facility for 20 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 188	Continued From page 25 shifts sampled for 13 days between 09/02/20 and 09/14/20. The facility's failure resulted in a lack of adequate staff required to provide personal care, and was detrimental to the health, welfare, and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 24, 2020 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 14, 2020.	D 188		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain	D 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 255	Continued From page 26	D 255		

of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;
(G) threat to life such as stroke, heart condition, or metastatic cancer;
(H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher;
(I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes;
(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to ensure care plans were completed within 10 days for significant changes for 2 of 9 sampled residents, (Resident #9 and Resident #2).

The findings are:

1. Review of Resident #9's current FL2 dated 03/03/20 revealed:
-Diagnoses included dementia, diabetes, hypertension and anxiety.
-She required assistance with bathing and dressing.
-She was incontinent of bowel and bladder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 255	Continued From page 27 -She was ambulatory. Review of Resident #9's care plan dated 05/09/20 revealed: -Resident #9 was ambulatory with the use of a walker. -Eating was (2) limited assistance cut meats. -Toileting was (3) extensive assistance. -Bathing was (4) totally dependent. -Grooming personal hygiene was (2) limited assist. -Documentation of activities of daily living (1) supervision was required for ambulation and transfers. Review of Resident #9's physical therapy (PT) notes dated 08/31/20 revealed: -Resident #9 was found in her room sitting in chair; lethargic and required physical assistance to awaken. -The findings were reported to the Administrator and the Infectious Disease Manager. -Resident #9 required physical assistance for all transfers. -PT notified the Primary Care Provider (PCP) Resident #9 declined in function and was lethargic. -PT assisted Resident #9 with eating, "food tray was not touched." Review of Resident #9's Home Health (HH) nurses notes dated 09/01/20 revealed: -The Registered Nurse had seen Resident #9 due to altered mental status. -Resident #9 required 2-person assistance to move from chair to bed. -Resident #9 had generalized muscle weakness. Review of Resident #9's HH nurses notes dated 09/03/20 revealed:	D 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 255	Continued From page 28	D 255		

-Resident #9 had dementia.
-Transfer should only be done with another person to prevent falls.

Review of Resident #9's HH notes for dated 09/14/20 revealed Resident #9 was seen by the HH nurse for wound care.

Further review of Resident #9's record revealed:
-There were no documentation of skin assessments.
-There was no updated care plan for significant changes within 10 days available for review.

Interview with the medication aide (MA) on 09/15/20 at 10:10am revealed:
-The MAs supervised the personal care aide (PCAs) and review the bathing logs, perform skin assessments of the residents, and document in the resident's progress notes.
-The MAs reviewed the care plans and inform the PCAs the level of care each resident required.
-The MAs communicated to the PCAs every shift with any changes in condition of residents or special needs.

Interview with the PCA on 09/15/20 at 1:42pm revealed:
-Resident #9 was bedbound and incontinent of bladder.
-Resident #9 required 2-person assistance with getting out of bed.
-Resident #9 could get in the wheel chair but "physical therapy would get her up."

Interview with the Administrator on 09/21/20 at 2:25pm revealed:
-Resident #9 was bedbound and required more assistance from staff.
-Resident #9 required feeding from the staff at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 255	Continued From page 29	D 255		

meal times.
-Resident #9 had multiple wounds and the HH nurse was treating Resident #9's wounds.
-She was unaware how often resident care plans were to be updated.
-She did not think Resident #9 had significant changes in mobility, transfers or a decline in her ADL's.
-"That is out of my scope of practice."

Interview with the sister facility Administrator on 09/21/20 at 2:25pm revealed:
-She was present with the interview with the Administrator on 09/02/20 at 2:25pm.
-She informed the Administrator the resident's care plans are due yearly except if significant changes occur, then they are completed within 10 days.

2. Review of Resident #2's current FL2 dated 05/01/20 revealed:
-Diagnoses included atrial fibrillation, cardiomyopathy, urinary retention, hypothyroidism and depression.
-She required assistance with bathing.
-She had an supra pubic catheter and was continent of bowel.
-Resident #2 was semi-ambulatory with a rollator.

Review of Resident #2's Care Plan dated 01/15/20 revealed:
-Resident #2 was ambulatory with the use of a rollator.
-She had a supra pubic catheter for urinary retention.
-Eating was (2), limited assistance with cutting meats.
-Toileting was (0), totally independent.
-Bathing was (0), totally independent.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 255	Continued From page 30 -Grooming and personal hygiene (0), totally independent. -Check weight daily was (4), totally dependent. Review of Resident #2's Licensed Health Professional Support(LHPS) documentation dated 07/07/20 revealed: -She was alert and able to make her needs known. -The personal care tasks identified were 'position, empty, and clean around urinary catheter and ambulation using assistive devices'. -Staff assisted the resident as needed with catheter care; resident provided own emptying of catheter. -Continue to follow Plan of Care signed by primary care provider (PCP) dated 01/15/20. Review of Resident #2's Home Health (HH) admission evaluation dated 03/03/20 revealed: -Resident #2 had a history of urinary retention, chronic urinary tract infections, congestive heart failure (CHF), hypertension, atrial fibrillation, dysphagia, depression and a supra pubic catheter. -Resident #2's skilled nursing assessment was: she required intermittent supervision, used a rollator to ambulate and required one person assistance to transfer. -Resident #2 required frequent rest periods due to increased shortness of breath and poor endurance. -Education provided to facility staff included: the importance of cleaning daily around the supra pubic catheter site and emptying the catheter bag as needed to prevent overflow of urine. Review of Resident #2's HH recertification evaluation dated 09/04/20 revealed: -The skilled nurse observed and assessed	D 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 255	Continued From page 31	D 255		

Resident #2 for dementia and instructed the caregivers in the proper management techniques of Resident #2's dementia.
-Resident #2's functional limitations were endurance, ambulation and dyspnea with exertion.
-Resident #2 should have the "assistance of another to assist with mobility".
-Skilled services were needed due to a self care deficit which resulted in difficulty with bathing safety, dressing, grooming, managing dyspnea, and managing edema.

Interview with the LHPS Registered Nurse (RN) on 9/23/20 at 2:43pm revealed:
-When she checked a task on the LHPS form it did not signify that the task should be performed by the staff or the resident, "I just identify tasks".
-She had never seen Resident #2 provide catheter care.
-She did not know if she needed assistance emptying her catheter and providing proper hygiene surrounding the maintenance of the catheter.
-She ensured staff could perform the necessary LHPS tasks.
-Catheter care was one of the tasks included in the staff check off.
-She referred to the FL2 when completing the LHPS reviews quarterly.

Interview with the medication aide (MA) on 09/15/20 at 10:10am revealed:
-The MAs supervised the Personal Care Aides (PCAs) documentation of the resident's bathing logs, performed skin assessments of the residents, and documented in the resident's progress notes.
-The MAs reviewed the resident's Care Plans and informed the PCAs the level of care each resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 255	Continued From page 32	D 255		

required.
-The MAs communicated to the PCAs every shift with any changes in condition or special needs of the residents.
-Resident #2 was independent with her showers and her catheter care.
-She emptied her catheter bag herself.

Interview with a PCA on 09/15/20 at 11:04am revealed:
-If the PCAs have anything to report, as it pertains to resident care, it would be reported to the MAs.
-She thought Resident #2 was independent with showers-maybe she needed assistance drying her feet.
-She did not know where a shower schedule was for the residents.
-She thought it had been at the nurses station.
-The staff knew when residents showers were-"when you have been here awhile you just know".
-The staff knew the resident's shower schedule because it had been the same for awhile.

Review of a shower schedule on 09/21/20 at 4:30pm revealed:
- Resident #2 was scheduled for a shower on Thursday evenings.
-The shower schedule did not indicate how much staff assistance was needed for each resident.

Observation of Resident #2 on 09/15/20 at 11:31am revealed:
-Resident #2 was in her bed, curled up with her eyes closed.
-Her catheter bag was lying on the floor under her bed and was full to capacity of urine.
-Resident #2 gave permission for surveyor to observe the placement of the catheter tubing.
-Resident #2 moaned and facial expressions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 255	Continued From page 33	D 255		

were consistent with verbalization that she hurt when staff turned her to the left side.
-The resident had a brief on and the catheter tubing was twisted around the brief and her legs.
-The brief had a small amount of feces inside and on the catheter tubing.
-The MA did not know how to remove the brief with the catheter tubing inside.
-Resident #2 needed assistance from staff to rise to a sitting position on edge of the bed and was moaning.
-Resident #2 was repeating that she wanted someone to wash her up and wash her hair.
-She stated she felt dirty and had not showered or washed her hair in a few weeks.
-Resident repeated several times that she felt unsteady.
-When asked to ambulate to the bathroom, Resident #2 stated she could not walk without assistance of staff and her rollator.
-Resident #2 needed coaxing, cues and stand by assistance with MA to ambulate with her rollator to the bathroom.
-Resident #2 had to stop several times because she was tired and was short of breath.
-She needed cues and prompts to position herself in front of the toilet.
-Resident #2 was unable to lift her catheter bag up to empty the urine in the toilet.
-Staff assisted her by holding the catheter bag.
-Resident #2 was unable to open the catheter port and release the urine.
-Staff needed to empty the urine in the catheter bag for Resident #2.
-Resident #2 ambulated back to her chair with frequent stops and requests to shower and wash her hair.

Interview with another MA on 09/15/20 at 1:45am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 255	Continued From page 34 -Resident #2 emptied her own catheter bag, -She changed her brief and showered independently. -Resident #2 ambulated with a rollator independently. Observation of Resident #2 on 09/16/20 at 7:45am revealed: -Resident #2 was lying in bed with her eyes closed. -The catheter bag was laying under her bed on the floor, full to capacity of urine. -The area around the catheter site was red and irritated and tender to the touch when staff provided care. -The Infection Control Manager (ICM) accompanied Resident #2 to the bathroom to demonstrate the emptying of the catheter bag. -Resident #2 requested a staff person assist during ambulation-"I am afraid I may fall." -She stopped frequently on the way to the bathroom due to shortness of breath and fatigue. -The ICM had 2 hands on Resident #2 to steady her while she attempted to lift the catheter bag over the toilet. -The ICM steadied the resident's hands and held the catheter bag. -Resident #2 was unable to release the catheter port to empty the catheter bag. Interview with the ICM on 09/16/20 at 8:00am revealed: -Resident #2 changed her own catheter bag and briefs. -She also showered independently. -Most of the residents on this floor were independent. Telephone interview with the HH clinical staff on 09/17/20 at 4:01pm revealed:	D 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 255	Continued From page 35	D 255		

-The Registered Nurse (RN) managing Resident #2's case, reported to the clinical staff, around the end of August, Resident #2 had a change in her baseline assessment.
-She was confused and was not taking care of her catheter bag, personal care and hygiene.

Telephone interview with Resident #2's responsible family member on 09/18/20 at 2:32pm revealed:
-Resident #2 needed to wear incontinent briefs for accidents she had with her bowels and leakage around the catheter site.
-She had advocated to have Resident #2 at a higher level of care.
-She had spoken to the Administrator back in March of 2020 and informed her that Resident #2 needed more assistance with personal care and catheter care.
-Resident #2 needed more cueing around activities of daily living due to a noticeable cognitive decline since early to mid August.

Telephone interview with Resident #2 on 09/24/20 at 11:44am revealed:
-She was short of breath when ambulating with her rollator.
-She had an inhaler she thought was on the medication cart.
-The inhaler helped with her shortness of breath but she would forget to ask the MA to bring it to her when she needed it.
-She was afraid to walk to the bathroom by herself. She was very unsteady.
-She used to empty her catheter bag independently, but now she needed the staff to assist her.
-Sometimes she would wake up and the catheter bag was full of urine.
-Some staff told her they did not know how to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 255	Continued From page 36	D 255		

empty the catheter bag.
-Some staff said it was her responsibility to empty the catheter bag.
-She reported to the staff that she needed assistance ambulating and taking a shower as well.

Interview with a second MA on 09/21/20 at 10:30am revealed:
-It was the MA/Floor Supervisor's responsibility to ensure the Care Plans for the residents reflected their current level of care.
-The MA/Floor Supervisor's would follow up with the primary care provider (PCP) and the family member if the resident's level of care changed.
-The MA/Floor Supervisor communicated the resident's level of care to the MAs and the PCAs.
-Care Plans were completed annually, or updated as needed, by the MA/Floor Supervisor's or the Resident Care Coordinator (RCC) when that position was filled.
-Currently the RCC position was vacant.

Interview with a PCA on 09/22/20 at 9:05pm revealed:
-She had been employed at the facility for one month.
-The MA's reported to the PCAs the type of care each resident needed.
-Most residents were independent on this floor.
-Residents requested the care they needed to the PCAs.
-The staff could refer to the binder which has the "Aide Weekly Task Schedule" for the care each resident needed, located at the nurses station.
-The PCAs were informed by the MAs that Resident #2 emptied her own catheter bag and was independent with her showers.

Review of the Aide Weekly Task Schedule on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 255	Continued From page 37 09/22/20 at 9:10pm revealed: -Resident #2 did not have a task schedule in the binder. -The last entry for residents with a task schedule in the binder was July 2020. Telephone interview with another MA on 09/25/20 at 1:24pm revealed: -Before Resident #2 became ill, at the end of August 2020, she could not remember a lot of things. -She could not identify the names of some objects or remember how to use her cell phone. -Resident #2 was still not fully aware. -She used to take showers independently and take care of her personal needs. -Now the staff had to coax her to take a shower. Interview with the Administrator on 09/21/20 at 3:00pm -The resident's Care Plans were completed by the MA/Floor Supervisor annually. -If there was a change in the level of care it would be reported shift to shift verbally by the MAs. -Resident #2 was very independent. -The staff offered assistance, but she preferred to do for herself. -She usually changed her own catheter bag, but sometimes she needed staff assistance. -Resident #2 ambulated with a rollator independently. Attempted telephone interviews with the current HH RN on 09/18/20 at 2:20pm and 09/21/20 at 10:37am were unsuccessful.	D 255		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 38 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 5 of 10 sampled residents (Resident #2, #9, #1, #7 and #17) including catheter care and personal care with showers and general hygiene (Resident #2); care for a strong smell of urine, a saturated incontinent brief, and multiple wounds (Resident #9); personal care and bathing (Resident #1); assistance with bathing, dressing, and incontinent care (Resident #7); and assistance with grooming, bathing, and dressing, as indicated in the Care Plan (Resident #17). The findings are: 1. Review of Resident #2's current FL2 dated 05/01/20 revealed: -Diagnoses included atrial fibrillation, congestive heart failure, urinary retention, degenerative joint disease and depression. -Resident #2 was semi-ambulatory with assistance of a rollator. -Resident #2 had a supra pubic catheter. Observation of Resident #2 on 09/15/20 at 11:31am revealed:	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 269	Continued From page 39 -During the initial tour of the facility on the third floor, Resident #2 was observed in her bed with a full catheter bag on the floor under her bed. -Surveyor asked the medication aide (MA) if she was passing medications to the residents at this time and she stated she was not passing medications at this time. -Surveyor asked if she could assist Resident #2 in getting to the bathroom. The MA agreed to assist. -Resident #2 was in the bed, limbs drawn in and eyes closed. -The catheter bag was full to capacity with urine, and lying under her bed on the floor. -The surveyor asked permission of Resident #2 to observe the catheter placement site and her perineal area and the resident agreed. -Resident #2 moaned and had facial expressions consistent with the verbalizations that she hurt when staff turned her to the left side. -There was a bruise noted above her left eyebrow of a yellow/purple coloring, a 50-cent size purple bruise on her left thigh and a quarter size purple bruise on her knee. -The MA was not aware of the bruising and was not aware of a recent fall or incident. -Resident #2 had an incontinent brief on, and the catheter tubing was twisted around the incontinent brief and her legs. -There were indentations on her skin where she had laid on the tubing. -The incontinent brief had a small amount of fecal matter inside and on the catheter tubing. -The area between Resident #2's buttocks were chafed, red and irritated. -There was skin breakdown inside the vaginal folds and thick mucus in the vaginal opening. -The site around the opening of the suprapubic catheter was red and tender to the touch when the MA was providing care.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 269	Continued From page 40 -The MA did not know how to remove the brief with the catheter tubing inside. -Resident #2 was weak and required a 2 person assist to raise herself to the side of the bed. -Even with the assistance of the staff, she struggled to rise and get to the side of the bed. -Resident #2 was softly moaning and was short of breath during this time. -Resident #2's hair was matted and greasy. Resident kept repeating that she wanted someone to "wash her up and wash her hair". -She continued to state she felt unsteady. -When asked to ambulate to the bathroom, she replied she could not walk without assistance. -Resident #2 needed coaxing, cues and stand by assistance with MA to ambulate with her rollator to the bathroom. -Resident #2 stopped several times on the way to the bathroom in her room and stated she was tired and short of breath. -Resident #2 needed cues and prompts to get to the toilet. -She was unable to lift her catheter bag up to empty the urine in the toilet. -Staff assisted her by holding the catheter bag. -The resident attempted to open the catheter port but was unable to open the plastic locking device. -Staff attempted to assist resident in unlocking the catheter port but was unsuccessful. -Surveyor explained the release mechanism of the plastic lock. -The MA did not wipe the catheter port after draining the urine and locking the port. -Resident #2 ambulated with her rollator back to her chair with frequent stops and repeated requests to shower and wash her hair. -Sitting in her bedroom chair it was observed Resident #2's feet were edematous bilaterally. -Resident #2 expressed no pain or discomfort in her feet.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 269	Continued From page 41 Interview with the MA on 09/15/20 at 11:50am revealed: -Resident #2 ambulated independently with her rollator and emptied her own catheter bag. -"I know how to empty a catheter bag, but I have not seen this type before." Observation of Resident #2 on 09/16/20 at 7:45am revealed: -Resident #2 was in her bed with her eyes closed. -Resident #2's catheter bag was again full to capacity with urine, placed under her bed on the floor. -She was in the same bathrobe she had on yesterday with some food stains on the front. -Resident #2's hair was greasy and matted. -The surveyor and the Adult Home Specialist (AHS) requested the Infection Control Manager (ICM) to come and assist the resident to the bathroom, since the staff were busy with morning care. -Resident #2's incontinent brief was soaked with urine. -The ICM was directed to the full catheter bag on the floor. -Resident #2 was unable to change her incontinent brief. -Resident #2 was asked permission for the surveyor and the AHS to observe staff changing the incontinent brief and observing her genital area. -Resident #2 agreed to the observation. -The abdominal area surrounding the suprapubic site was tender to the touch when staff was changing her brief. -The area around the supra pubic site was red and irritated. -Resident #2 stated she used to have a cream to put around the site, but she had not had it for a	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 269	Continued From page 42	D 269		

while and didn't know where it was.
-She did not want to ambulate without a staff person due to her unsteadiness and fear of falling.
-The ICM assisted the resident to the bathroom.
-Resident #2 required several stops on the way to the bathroom due to fatigue and shortness of breath (as stated by the resident).
-Resident #2 required cues and prompts to stay on task.
-The ICM placed 2 hands on Resident #2's upper body as she tried to steady the resident who was attempting to lift the full catheter bag over the toilet.
-Resident #2 was unable to hold the catheter bag independently or open the port to drain the urine.
-The ICM had to open and close the catheter bag port for Resident #2.
-Neither Resident #2 or the ICM cleaned the port when the task was completed.

Interview with the ICM on 09/16/20 at 7:55am revealed:
-The ICM stated Resident #2 changed her own catheter bag and briefs.
-She ambulated with her rollator and showered independently.

Review of Resident #2's rehabilitation discharge summary dated 03/06/20 revealed:
-Resident #2 was admitted to the rehabilitation facility and diagnosed with generalized weakness due to a hospitalization with pneumonia.
-Resident #2 was discharged on 03/15/20 with a discharge summary to continue catheter care per facility protocol for chronic urinary retention with suprapubic catheter.

Review of Resident #2's Home Health (HH) notes dated 03/09/20 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 43 -Upon assessment for start of care, Resident #2 needed ongoing monitoring for urinary retention which caused difficulty affecting daily functioning. -Resident was totally dependent in toileting. -The resident required assistance to maintain toileting hygiene and adjust clothing. -Resident #2 required the presence of another person throughout the bath for assistance or supervision. -She needed assistance with undergarments, slacks, socks and shoes. -She ambulated with supervision or assistance of another person at all times. Review of Resident #2's Licensed Health Professional Support (LHPS) dated 07/07/20 revealed: -Position, empty and clean around the supra pubic catheter was documented as a marked task for Resident #2. -Staff assisted resident as needed with catheter care and the resident provided her own emptying of catheter. -Staff competency was validated for catheter care. Telephone interview with the LHPS Registered Nurse (RN) on 09/23/20 at 2:43pm revealed: -It was her responsibility to conduct the LHPS personal care task review for the residents and the staff. -When she identified a task on the LHPS form, it did not signify that the task should be performed by the staff or the resident. -She just identified a needed task. -She had never seen Resident #2 provide catheter care or empty her catheter. -She did not know if Resident #2 needed assistance in emptying her catheter bag and providing proper hygiene surrounding	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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(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 269	Continued From page 44	D 269		

maintenance of the supra pubic catheter.
-Catheter care was one of the tasks identified and taught during the staff LHPS check off.
-She did not require a return demonstration for catheter care.
-The task was taught using visualizations.
-She referred to the resident's FL2 when completing the quarterly LHPS.

Review of Resident #2's HH notes dated 07/06/20 revealed:
-Skilled services were needed for Resident #2 due to a self-care deficit from a prior level of function.
-This resulted in difficulty in the resident's ability to access shower, bathing safety, dressing, managing dyspnea, managing hygiene, managing toileting, self-management of conditions or illness.
-The HH recommendations were signed by the primary care provider (PCP) on 07/17/20.

Telephone interview with Resident #2's HH clinical staff on 09/17/20 at 4:01pm revealed:
-Resident #2 was opened for care on 03/06/20 for nursing, physical therapy and occupational therapy post hospitalization and rehabilitation for pneumonia and generalized weakness.
-Nursing had continued care to the present due to chronic urinary retention and care of the suprapubic catheter.
-HH RN flushes the catheter once a week and changes the bag monthly.
-During a scheduled visit with Resident #2, around the end of August, the HH Registered Nurse (RN) found the resident confused, lethargic and very different from her baseline.
-In early August, Resident #2 was ambulatory to the bathroom with her rollator and changed her catheter bag frequently-the catheter bag was

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 269	Continued From page 45	D 269		

never very full.
-She had always been meticulous in her personal care and appearance.
-At present, Resident #2 was not taking care of her catheter bag, personal care or hygiene.

Review of Resident #2's HH notes dated 09/04/20 revealed:
-At the scheduled HH visit, the RN assessed Resident #2 as "very lethargic.
-She could not tell the RN her date of birth or name, which was not Resident #2's baseline.
-She noted Resident #2 required one person for assistance and used a rollator for mobility.
-Resident #2 required frequent rest periods due to increased shortness of breath and poor endurance.

Interview with another MA on 09/15/20 at 10:10am revealed:
-Resident #2 preferred to take care of her own needs.
-She was very independent with her shower and catheter bag.
-She emptied the catheter bag herself.
-She had not been notified of a change in Resident #2's personal care needs.

Telephone interview with Resident #2's responsible family member on 09/18/20 at 2:32pm revealed:
-The family member had advocated for a higher level of care for her loved one.
-She had spoken to the Administrator at the facility as far back as March 2020 when Resident #2 was discharged from rehabilitation.
-She relayed to the Administrator Resident #2 needed more assistance from the staff with her personal care and her catheter care.
-Some of the staff said they did not know how to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 269	Continued From page 46	D 269		

empty the catheter bag and some of the staff said it was Resident #2's responsibility.
-There were also times the staff did not wake her up for meals. The meal would be sitting on the tray beside her bed.
-Resident #2 also needed more cueing and prompting for daily tasks.
-Resident #2 had quite a cognitive decline in the past month.
-She had not spoken with Resident #2 on the phone or received a text response from her since mid-August (08/18/20).
-When she contacted the facility to determine why she had not been able to communicate with Resident #2 through her cell phone, the staff related Resident #2 did not want to talk to anyone.
-This was a "big change" in her behavior.
-Resident #2 tested positive for COVID-19 on 09/04/20 and had a urinary track infection.
-Resident #2 also had a fall sometime during September that she was not notified of.
-When the family member finally spoke with Resident #2, she said the staff had not been providing her personal care.
-She had not had a shower or hair washed and no assistance with emptying her catheter bag.

Interview with the MA/Floor Supervisor on 09/21/20 at 8:45am revealed:
-Resident #2 ambulated independently with her rollator, toileted herself and the staff provide stand by assistance with showers.
-When Resident #2 was sick the staff provided total care for 3 weeks.
-The MAs emptied her catheter bag and checked on her every 2 hours.
-If her catheter bag was full, the staff would empty the bag during the 2-hour checks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 269	Continued From page 47 Interview with two Personal Care Aides (PCAs) on 09/22/20 at 9:05pm revealed: -The PCAs were responsible for the personal care of the residents on the third floor and stocking the gloves, wipes and any other personal care items needed. -One PCA had been employed at the facility for one month and was training a second PCA on her first night. -The MA reported to the PCAs the care needed for each resident at shift change. -Most of the residents were independent on this floor (The 3rd floor where COVID-19 residents were located while ill from the virus). -She knew the care tasks to provide each resident because the residents requested certain tasks during the shift. -The staff could refer to the binder at the nurse's station which had the "Aide Weekly Task Schedule" for each resident. -Resident #2 showers herself independently in her room, ambulates independently and empties her catheter independently. -The PCA providing the training to the new staff stated, "I don't know how to empty a catheter bag". -The PCAs received an oral report on each resident before the shift from the MA/Floor Supervisor or the previous shift's PCAs. Review of the "Aide Weekly Task Schedule" on 09/22/20 at 9:10pm revealed: -The Task schedule was in a binder at the nurse's station. -The PCA's stated they could refer to this form and determine the care needed to be provided to each resident. -Resident #2 did not have a weekly task schedule in the binder. -The last dated entry, for resident's weekly task	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 269	Continued From page 48	D 269		

schedule included in the binder, was 07/08/20 through 07/13/20.

Interview with a second shift MA on 09/22/20 at 8:20pm revealed:
-She had been a MA for 3 years and started at this facility in April 2020.
-If you were "in tune with the residents, you could tell when something was off with them".
-She was in tune with her residents.
-She visited them and spoke with them during her shift.
-She interacted with the residents, so she knew what their needs were.
-A new staff would be instructed as to the proper care of residents by the person training them.
-The MA on each shift communicated information regarding patient care to the PCAs.
-The staff offered to assist Resident #2 with showers and ambulation, but she refused.
-Resident #2 showered independently in her room.
-Resident #2 was a private person.

Telephone interview with a second MA/Floor Supervisor on 09/25/20 at 1:24pm revealed:
-Resident #2 could not remember a "lot of things" before she became ill in August.
-Resident #2 could not identify "names of things or use her phone" before she became ill.
-She used to take showers independently and was able to take care of herself.
-Now the staff tried to coax her into the shower, but she refused.

Telephone interview with the Ombudsman on 09/23/20 at 4:42pm revealed:
-She had been in contact with Resident #2 weekly for months.
-Resident #2 complained staff were not assisting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 269	Continued From page 49	D 269		

her with catheter care.
-The catheter bag would get full and the staff would not empty it.
-Some of the staff said they did not know how to empty the catheter bag, and some of the staff told Resident #2 it was her responsibility.
-She stated she needed more care than the staff was willing to provide.

Telephone interview with Resident #2 on 09/24/20 at 11:44am revealed:
-She was short of breath when she ambulated with her walker. (Observed on 09/21/20 when ambulating with walker and talking).
-She was afraid to walk to the bathroom by herself because she was very unsteady.
-She used to empty her own catheter bag, however she needed the staff to assist now.
-Sometimes she woke up and the bag was full of urine.
-Some staff said they did not know how to empty the catheter bag, and some staff said that it was her responsibility to empty the catheter bag.
-Since she was ill, she needed assistance with transfers, ambulating with her rollator, emptying her catheter bag and taking a shower.
-She had been asking for a shower for a long time.
-Resident #2 stated she felt dirty and had not showered or washed her hair "in a few weeks".
-Resident stated when she was able to provide personal care to herself, she took frequent showers. She did not like being dirty.
-She finally was assisted by staff in the shower yesterday.

Review of staff qualifications on 09/21/20 revealed 3 of the 4 staff had LHPS check off for catheter care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 269	Continued From page 50 Telephone interview with the HH Clinical Manager on 09/24/20 at 10:10am revealed: -HH nurses have educated the staff and residents on perineal care, care at the site of the catheter insertion and emptying the catheter bag. -An in service was provided by the HH RN for the facility staff on March 10, 2020 from 8:30-2:30pm. -The in service included catheter care, perineum care and safety with transfers. -Resident #2 was discharged from rehabilitation on 3/16/20. -The discharge summary included-chronic urinary obstruction-provide catheter care per facility policy. Telephone interview with HH clinical RN on 9/30/20 at 9:15am revealed: -She was the primary HH RN at the facility until July 2020. -In February 2020, the HH staff were observing skin breakdown, an increase in falls and poor catheter care with the residents they had as clients at this facility. -As the residents declined physically and mentally, including Resident #2, they were no longer able to provide the care and maintenance of their catheters independently. -The HH RN wanted to make sure that as these residents' ability to self-maintain their catheter care declined, the staff would be able to empty their catheter bags, clean the perineal area properly and ensure proper placement of the catheter. -She approached the Administrator with these concerns, and the Administrator agreed an in-service for the staff provided by the HH RN on 4 key areas would be provided: incontinence and skin care; catheter care; handwashing; and transfers and safety. -Various catheter bags and port locking devices	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 269	Continued From page 51	D 269		

were displayed to the staff during this in-service.
-The in-service class was held on 03/10/20. The first session was held from 8:30am-9:45am; the second session from 2:40pm-3:45pm.
-The education included return demonstration, and emphasized catheter bags should be emptied frequently and should never be lying on the floor.
-If a catheter bag was full of urine, the resident may not be able to empty the bag independently and/or the bag may become compromised.
-The HH RN also provided the Administrator and staff with the names of residents who needed to be checked every 2 hours and reminded to empty their catheter bags.
-Resident #2 was one of the names provided to the Administrator and staff who needed to be checked every 2 hours and reminded to empty their catheter bags.
-This was a service the HH agency provided to the facility, so the staff roster of those in attendance was given to the Administrator.
-The Administrator placed the roster in the "Educational Folder" in her office.
-The HH RN provided a list of participants who attended the in service and were currently employed at the facility.
-Resident #2 was meticulous in her catheter care and personal care prior to my last visit in June.
-Resident #2 emptied the catheter bag often and always hung the bag on her walker.
-Resident #2 would request alcohol pads frequently to clean the port after emptying the catheter bag.
-Resident #2 never allowed the catheter bag to be on the floor.
-The HH RN was responsible for irrigating the catheter weekly and changing the catheter bag monthly.
-Emptying a catheter bag was not a skilled task

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 269	Continued From page 52	D 269		

and the HH RN would not be providing that service.

Telephone interview with the Administrator on 09/29/20 at 2:35pm revealed:
-Resident #2 was independent with the care of her catheter.
-The staff were not instructed to empty Resident #2's catheter bag. Resident #2 was responsible for emptying her catheter bag.
-In the event Resident #2's catheter bag was full and she could not empty it, we would obtain an order from the physician to discontinue the self administration order for catheter care.
-In the interim, we would call the HH nurse to come to the resident's room, if she was in the building, to empty Resident #2's catheter bag.

A request was made on 09/21/20 at 2:30pm for the policy on catheter care, but was not provided by exit on 09/30/20.

Refer to interview with MA/Floor Supervisor on 09/15/20 at 10:10am.

Refer to interview with a personal care aide (PCA) on 9/15/20 at 11:04am.

Refer to interview with MA on 09/21/20 10:30am.

Refer to Telephone interview with the Administrator on 09/29/20 at 2:35pm.
2. Review of Resident #9's current FL2 dated 03/03/20 revealed:
-Diagnoses included dementia, diabetes, hypertension and anxiety.
-Resident #9 was ambulatory.
-Resident #9 was incontinent of bowel and bladder.
-Resident #9's skin was normal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 269	Continued From page 53 Review of Resident #9's care plan dated 05/09/20 revealed: -Resident #9 was ambulatory with the use of a walker. -Her skin was normal. -Her speech was normal. -Resident #9's activities of daily living were (4) totally dependent for bathing and dressing. Review of Resident #9's physical therapy (PT) notes dated 08/31/20 revealed: -Sit to stand transfers Resident #9 was total dependent on staff. -Resident #9 could not achieve a full upright position. -Resident #9 required assistance with all transfers. -Documentation PT notified the Nurse Practitioner (NP) Resident #9 declined in function and was lethargic. Review of Resident #9's Home Health (HH) nurses notes dated 09/01/20 revealed: -Nurse saw Resident #9 due to altered mental status. -Resident #9 required 2-person assistance to move from chair to bed. -Resident #9 had generalized muscle weakness. Review of the HH notes for Resident #9 dated 09/14/20 revealed: -Resident #9 tested COVID-19 positive. -Resident #9 was being seen by the nurse for wound care. -Resident #9 was non-verbal. -Resident #9 had a skin tear to her right shoulder and a deep tissue injury to her right hip. -Resident #9 was bedridden and dependent on staff for feeding and activities of daily living.	D 269		

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 269	Continued From page 54 -Education was given to the facility staff regarding Resident #9 required tuning and reposition every 2 hours to prevent further breakdown. -She informed staff Resident #9 should be changed and washed with soap and water, skin barrier cream should be applied to buttocks to prevent skin breakdown. Observation on 09/15/20 at 1:42pm of Resident #9 in her room revealed: -The personal care aide (PCA), the Infection Control Manager, and the local county Adult Home Specialist were present in Resident #9's room. -Upon entering, the room smelled of a strong urine odor. -Resident #9 was laying in the bed on her back, she was nonverbal. -There was a light greenish-blue bruise to the middle of her forehead approximately 2 inches long and 1 inch wide. -There was dark blue bruising to both forearms and hands. -There was a dressing to her right shoulder. -There was a dark red circular area to her right hip approximately 3 inches long and 2 inches wide. In the center of the dark red area was a wound approximately 1.5 x 1 inch. The wound had blackish-brown thick tissue with a whitish yellow tissue border around the wound. -There were 3 circular red areas each approximately 1 inch to her sacral region; 1 area directly in the middle of her sacral near the coccyx and 2 on each side of the coccyx. -Resident #9's incontinent brief was saturated with yellowish-dark urine. -Her peritoneal area was reddened as well as her upper inner thigh. -Her nails on both hands were long and uneven and had a brownish substance under the nails.	D 269		

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D 269	Continued From page 55 -Resident #9 did not communicate or respond to the facility staff or the survey team during the assessment. Interview with the PCA present in Resident #9's room on 09/15/20 at 1:42pm revealed: -Resident #9 was COVID-19 positive and was in a private room. -Resident #9 was bedbound and incontinent of bladder. -Resident #9 was to be turned and repositioned every 2 hours. -She had provided personal care for Resident #9 before lunch around 11:30am. -She did not document changing brief or turning and repositioning Resident #9 every 2 hours. -She knew Resident #9 had multiple areas of bruising and wounds, "home health is seeing her." -Resident #9 required 2-person assistance with getting out of bed. -Resident #9 could get in the wheelchair but physical therapy would get her up. -The medication aides (MA) and the Administrator were aware of Resident #9's bruising and the wounds. Telephone interview with the HH nurse on 09/17/20 at 11:35am revealed: -She was in the facility daily seeing residents. -She found Resident #9 with saturated incontinent briefs and the smell of urine multiple times when she performed care. -She had seen Resident #9 twice weekly for falls and wound care. -She documented in her notes speaking to the MAs and the Administrator regarding turning and repositioning Resident #9 every 2 hours. -She had not seen documentation the facility staff were turning Resident #9 every 2 hours.	D 269		

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D 269	Continued From page 56 Interview with a MA on the second floor on 09/15/20 at 4:10pm revealed: -Resident #9 tested positive for COVID-19 at the ER on 09/12/20. -Resident was in a private room on the second floor. -Staff were to turn and reposition Resident #9 every two hours because "she was bedbound." -The facility did not have a 2-hour turn documentation form. -The staff, "Just do it." -Resident #9 should be provided toileting every 2-hours. Observation of Resident #9 in her room on 09/18/20 at 10:26 am revealed: -The MA and the HH PT were present in Resident #9's room. -Resident #9 was lying in bed on her back. -Resident #9 had a dressing to her right hip. -There was a reddened area above the dressing approximately 4 X 4 inches on Resident #9's right hip, a white cream was over it. -The sacral area had a large redden area that had a smaller open excoriated wound, there was no dressing or cream over the sacral wound. -There was a quarter size reddened area to the left hip with a white cream over the area. Interview with the HH PT on 09/21/20 at 10:00am revealed: -Resident #9 was in her wheelchair on 09/18/20 and staff were feeding her. -It appeared Resident #9 was not swallowing the food. -She thought Resident #9 was aspirating with the food. -Resident #9's pulse was thready (rapid pulse that feels like a mobile thread under the palpating	D 269		

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D 269	Continued From page 57	D 269		

finger).
-Resident #9 was sent out to the emergency department (ED) on 09/18/20.

Review of Resident #9's ED note dated 09/18/20 revealed:
-Reason for admission was alerted mental status and lactic acidosis and elevated white blood count.
-Documentation Resident #9 was lethargic.
-Resident #9 was administered lactated ringers to improve hydration and cefepime (an antibiotic) intravenously (IV) as well as vancomycin (an antibiotic) IV for the possibility of sepsis.
-Documentation Resident #9 had wounds on her right shoulder, right hip and sacrum which were all stage 2 decubitus ulcers.
-Resident #9 was admitted to the hospital for evaluation.

Interview with the Administrator on 09/21/20 at 2:25pm revealed:
-Resident #9 was bedbound and required more care.
-The staff were to check Resident #9 every 2 hours and provide personal care which included changing her brief.
-The staff were to assist Resident #9 with her personal care.
-She had not looked at Resident #9's wounds.
-She knew HH were seeing Resident #9 for wound care.
-The MAs and the MA/Floor Supervisors were to report any changes in condition or skin breakdown to her.
-Staff had not reported any changes in Resident #9's care to her.
-She was unsure how Resident #9 received the bruising and skin tears documented on 09/07/20.

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D 269	Continued From page 58 Telephone interview with Resident #9's family on 09/21/20 at 8:07pm revealed: -Resident #9 was taken to the ER on 09/18/20. -The ER doctor called with concerns of the wounds on Resident #9's right hip, right shoulder and the sacral area. - "I was shocked [Resident #9] had bedsores." Telephone interview with the Social Worker from the local hospital on 09/22/20 at 3:09pm revealed: -Resident #9 was currently a patient in the hospital. -Resident #9 would be discharged to a skilled nurse unit for rehab and wound care. Telephone interview with the Registered Nurse from the local hospital on 09/22/20 at 3:40pm revealed: -She was the bedside nurse caring for Resident #9. -The wound care nurse had seen Resident #9 via virtual visit to assess the wounds. -The ulcer to Resident #9 right hip involved full thickness skin lost and was classified as a Stage 3 ulcer. -The ulcer to Resident #9's right shoulder was classified as practical thickness Stage 2 ulcer. -The ulcer to Resident #9's sacral was deep tissue injury (a pressure related injury beneath the skin). Telephone interview with Resident #9's primary care provider (PCP) on 09/21/20 at 9:10am revealed: -The HH PT reported Resident #9 was declining in her mobility in August 2020. -She was aware Resident #9 was sent out to the ED on 09/08/20 and on 09/18/20. -She was not made aware Resident #9 was	D 269		

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D 269	Continued From page 59	D 269		

bedbound.
-She was aware of the right hip wound, but not the wound to the right shoulder or the sacral area.
-She expected the staff to inform her of any change in condition or skin breakdown so she could treat the resident.
-To prevent skin breakdown Resident #9 should be turned and repositioned every two hours.
-She knew Resident #9 was incontinent of bladder.
-Her expectation was for staff to check for incontinence every 2 hours and as needed.

Refer to interview with a MA/Floor Supervisor on 09/15/20 at 10:10am.

Refer to interview with a personal care aide (PCA) on 9/15/20 at 11:04am.

Refer to interview with a MA on 09/21/20 10:30am revealed:

Refer to telephone interview with the Administrator on 09/29/20 at 2:35pm revealed:

3. Review of Resident #1's current FL2 dated 08/13/19 revealed:
-Diagnoses included diabetes, osteoarthritis, cervical spondylosis.
-Resident was semi-ambulatory.
-Resident was incontinent of bladder and continent of bowel.
-Resident required assist with her bathing and dressing.
-Functional limitations included sight.

Review of Resident #1's care plan revealed:
-There was no date the care plan was completed.
-The date of most recent primary care provider (PCP) exam was 07/30/20.

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D 269	Continued From page 60	D 269		

-Resident #1 was ambulatory with a rollator walker.
-Resident #1 was occasional incontinent of bladder.
-Resident #1 was oriented.
-Activities of daily living had a "X" on all the days of the week, and for all activities.
-There was a physician signature dated 08/10/20.

Interview with Resident #1 on 09/15/20 at 10:55am revealed:
-She tested positive for COVID-19 and resided on the third floor.
-She had been sick and weak and could not provide personal care to herself when she had COVID-19.
-During the facility's quarantine for COVID-19 staff would not come in her room to assist with personal care, bathing or changing her gowns.
-"I went 14 days without a shower or bath."
-"Staff were rude to me when I ask for help."
-"Staff would bring my pills in the morning and then I would not see anyone else."
-"The only time I had my linens changed was when I had an accident in bed, they had to change them."

Telephone interview with Resident #1's Power of Attorney (POA) on 09/18/20 at 10:05am revealed:
-Resident #1 called her daily to tell her she was weak, not feeling well and was sick.
-Resident #1 told her she had not had a shower or bath in 14 days.
-Resident #1 said she did not have her linens changed during the COVID-19 pandemic for 10 to 14 days.
-Resident #1 complained of diarrhea on several occasions.
-"She [Resident #1] kept asking for help, but the

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D 269	Continued From page 61	D 269		

staff did not give her any help."
-"You cannot imagine how I felt being 2 hours away from [Resident #1] and I could do nothing."
-Resident #1 was so weak at times she could not understand her.

Interview on 09/16/20 at 11:00am with the Administrator revealed:
-The residents who tested positive for COVID-19 were moved to the third floor on the back-hall way.
-She knew Resident #1 tested positive for COVID-19.
-Resident #1 was alert and oriented.
-She was not aware Resident #1 complained of not feeling well and requested to go the doctor when she had COVID-19.
-She did not know Resident #1 went 14 days without a shower or bath.
-She was not aware staff were not providing Resident #1 with personal care during those 14 days.

Telephone interview with the temporary Administrator and the Chief Operating Officer (COO) on 09/29/20 at 1:15pm revealed:
-Residents were to receive personal care according to the care plan and needs.
-She expected PCAs to complete personal care tasks daily to meet the needs of the residents.
-They were not aware Resident #1 went 14 days without a shower or bath.

Refer to interview with a MA/Floor Supervisor on 09/15/20 at 10:10am.

Refer to interview with a personal care aide (PCA) on 9/15/20 at 11:04am.

Refer to interview with a MA on 09/21/20 10:30am

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 269	Continued From page 62 revealed: Refer to telephone interview with the Administrator on 09/29/20 at 2:35pm revealed: 3. Review of Resident #7's current FL2 dated 04/30/20 revealed: -Diagnoses included pelvic fracture, chronic obstructive pulmonary disease, and vascular dementia. -Bathing and dressing were checked as personal care tasks in which the resident required assistance. -The resident was semi-ambulatory. -The resident was continent with bowel and bladder. Review of Resident #7's Care Plan dated 01/14/20 revealed: -The resident required extensive assistance with bathing and dressing. -The resident required limited assistance with grooming. Observation of Resident #7 on 09/15/20 at 11:35am revealed: -Resident #7 was sitting in his room in a chair across from his television. -He was disheveled, his jeans were positioned below waist sitting at thigh level exposing a incontinent brief. -The resident had on a grey shirt with food stains on the front. -His hair was matted and greasy and he was unshaved. -The resident appeared to not had a shower. Review of the facility shower schedule (undated) revealed Resident #7 was to get a shower on Sunday, Wednesday, and Saturday.	D 269		

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D 269	Continued From page 63 Observation of Resident #7 on 09/16/20 at 10:00am revealed: -The resident still had on the grey shirt with food stains in the front. -His hair was still matted, greasy, and he was unshaved. -The resident still appeared to not had a shower. Observation of Resident #7 on 09/21/20 at 3:22pm revealed: -The resident was lying in his bed resting. -The resident's room smelled of a stale bowel movement. Interview with the contracted physical therapist (PT) on 09/17/20 at 4:01pm revealed: -The resident was opened for PT after a recent hospitalization 09/11/20. -Resident #7 was assessed as maximum assistance with transfers and a one person assist with his walker. -On 09/11/20 she observed Resident #7's clothes being dirty. -She had a hard time finding clean clothes for him. -She picked the least dirty clothes and assisted him with dressing. -She could not find any incontinent briefs for him. -She alerted the staff on 09/11/20 Resident #7 needed his laundry to be done. -When she provided therapy on 09/14/20, Resident #7 was in the same clothes and his laundry still wasn't cleaned. -She changed the resident into jeans and a grey top. -She educated staff on his needs on 09/14/20. -She could not remember the name of the staff she educated. -She contacted staff to assist Resident #7 with his	D 269		

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D 269	Continued From page 64	D 269		

pants when she was providing therapy on 09/14/20.
-She had to assist him to a standing position, she had to pull up his pants and lower him back to chair.

Interview with a first responder with emergency management services (EMS) on 09/14/20 at 3:21pm revealed:
-The staff person was on a team that responded to a call at the facility on 09/04/20.
-Resident #7 was observed disheveled, dirty, and sitting in soiled pants.
-Upon leaving the facility, the responder observed approximately 8 staff sitting around on the first floor in the common area.

Interview with a personal care aide (PCA) on 09/15/20 at 9:14am:
-Most of the residents, including Resident #7 on the 3rd floor were independent with personal care.
-Resident #7 was capable of completing personal care tasks independently.
-She did not need to assist Resident #7 with a shower.
-She did not refer to the care plan to determine the personal care tasks.
-Residents notified her if they required assistance with personal care duties.
-Resident #7 had not notified her that he required assistance.

Interview with a medication aide (MA) on 09/22/20 at 8:20pm revealed:
-Resident #7 was independent with his personal care and preferred to do for himself.
-She provided cueing for Resident #7 sometimes, but he preferred to do for himself.

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D 269	Continued From page 65 Interview with the primary care provider (PCP) for Resident #7 on 09/23/20 at 11:02am revealed: -Resident #7 required care as indicated in the care plan and she expected the resident to receive care as indicated on the care plan. -She did not know the resident required assistance with incontinent care, however stated that if ability changed, she would expect staff to assist. -She was not notified that the resident had not been receiving showers or that he refused any assistance with dressing, grooming, or incontinent care. Interview with the temporary Administrator and the Chief Operating Officer (COO) on 09/29/20 at 1:15pm revealed: -Residents were to receive personal care according to the care plan and needs. -She expected PCAs to complete personal care tasks daily to meet the needs of the residents. -Staff often completed tasks according to the preference of the resident. -She did not know personal care was not completed for Resident #7. Based on observations, interviews and record review it was determined Resident #7 was not interviewable. Refer to interview with a MA/Floor Supervisor on 09/15/20 at 10:10am. Refer to interview with a personal care aide (PCA) on 9/15/20 at 11:04am. Refer to interview with a MA on 09/21/20 10:30am. Refer to telephone interview with the	D 269		

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 269	Continued From page 66 Administrator on 09/29/20 at 2:35pm. 4. Review of Resident #17's most recent FL2 dated 08/21/19 revealed: -Diagnosis included diabetes, bipolar disorder, and hypertension. -The resident was ambulatory. -She was incontinent with bladder and bowel. -The resident required assistance with bathing and dressing. Review of Resident #17's Care Plan dated 01/07/20 revealed: -The resident required extensive assistance with bathing and dressing. -The resident required limited assistance with grooming and personal hygiene. Observation of Resident #17 on 09/15/20 at 12:15pm revealed: -The resident was lying on her bed watching television with the back of her feet facing the floor. -The resident's feet were dirty, layered with a grayish black dirt substance. -The resident was disheveled and her hair was greasy. -The resident was clothed in black pants and a purple paisley shirt. Interview with Resident #17 on 09/15/20 at 12:15pm revealed: -She could not remember the last time she had a shower. -She had not changed clothes since waking up. -She could not remember the last time she changed her clothes. -The staff had not assisted her with completing showers or grooming. -She could not remember if staff offered	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 269	Continued From page 67	D 269		

assistance with showers or grooming.
-She did not know when her shower days were scheduled.

Review of the facility's shower schedule (undated) located at the second floor nurse's station revealed Resident #17's showers were scheduled on second shift on Tuesday, Thursday, and Saturday.

A second observation of Resident #17 on 09/16/20 at 9:56am revealed:
-The resident's feet were still dirty, layered with a grayish black dirt substance.
-The resident appeared to be disheveled and her hair was greasy.
-The resident was clothed in black pants and a purple paisley shirt, the same outfit from 09/15/20.

Review of the resident shower book on the 2nd floor on 09/15/20 revealed:
-There was one refusal documented on 07/09/20 for Resident #17.
-The form indicated the resident stated it was too late to take a shower.

Interview with a medication aide (MA) on 09/22/20 at 8:41pm revealed:
-Residents were asked if they needed assistance with showers or personal care.
-Staff had access to the care plan in the binder that could be reference when needed.
-If residents refused showers, "we try again, then notify the floor supervisors and document in the care notes".
-Refusals were also documented on a shower refusal form and placed in the binder at the nurses' station.

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D 269	Continued From page 68 Interview with a personal care aide (PCA) on 09/22/20 at 8:29pm revealed: -She had been working on the second floor since 5:00pm on 09/22/20. -She was responsible for assisting residents with personal care tasks including bathing. -She had not completed any showers nor provided personal care for residents since the beginning of her shift on 09/ 22/20 because she had been assisting with snacks. -Resident #17 often refused showers, we document on the shower refusal forms and notify the floor supervisor. -She had notified the floor supervisor of Resident #17 refusing showers. -Resident #17's body odor was "unbearable" at times. Observation of the 2nd floor on 09/22/20 from 8:05pm-9:10pm revealed: -All residents were in their rooms with the doors closed. -The lights were dim in the hallways. -There were no observations of staff providing showers or personal care. Interview with MA/Floor Supervisor on 09/22/20 at 8:56pm revealed: -She did not know the last time Resident #17 was bathed. -PCAs were responsible for providing personal care assistance to residents. -If the resident refuses care or showers, PCAs were responsible for trying again, and they still refuse PCAs are to record on the refusal form. -The refusal forms went to the Administrator. -PCAs were responsible for completing personal care sheets to record tasks completed. -The personal care sheets were an internal document that could not be shared.	D 269		

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D 269	Continued From page 69	D 269		

-Resident #17 refused showers, we try to give her snacks to encourage showers, however she refused the last two showers.
-Resident #17's refusals were recorded on the refusal form and given to the Administrator.

Telephone interview with the primary care provider (PCP) for Resident #17 on 09/23/20 at 11:02am revealed:
-Resident #17 required care as indicated in the care plan and she expected the resident to receive care as indicate on the plan.
-She was not notified that the resident had not been receiving showers or that he refused any assistance with dressing, or grooming.
-She had not been notified that the resident refused any personal care assistance.
-Due to the COVID-19 pandemic, she had been completing tele-visits and was unable to get an observation of the resident's overall appearance.

Telephone interview with the temporary Administrator and the chief operating officer (COO) on 09/29/20 at 1:15pm revealed:
-Residents were to receive personal care according to the care plan and needs.
-She PCAs to complete personal care tasks daily to meet the needs of the residents.
-Staff often completed tasks according to the preference of the resident.
-She did not know personal care was not completed for Resident #17.

Refer to interview with a MA/Floor Supervisor on 09/15/20 at 10:10am.

Refer to interview with a personal care aide (PCA) on 9/15/20 at 11:04am.

Refer to interview with a MA on 09/21/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 269	Continued From page 70 10:30am. Refer to telephone interview with the Administrator on 09/29/20 at 2:35pm. _____ Interview with a lead MA on 09/15/20 at 10:10am revealed: -The MA/Floor Supervisor supervised the bathing logs, do skin assessments of the residents, and charting in the resident's chart. -The MA/Floor Supervisor notified the physician if necessary, and for clarification of orders. -The MAs reviewed the Care Plans and informed the PCAs of the care each resident required. -The MAs communicate to the PCAs during shift report any changes in condition of residents or special needs. Interview with a personal care aide (PCA) on 9/15/20 at 11:04am revealed: -She reported to the MAs if there was a change of condition for any of the residents. -The staff knew when the residents were scheduled for their showers. -When you have been working at the facility for a while you just know-you do not need to refer to the shower schedule. -The residents showers were the same day every week. -She did not know where a shower schedule was for the residents. "It used to be at the nurse's station." -"We just know when it is the resident's day because its been the same for a while." Interview with a MA on 09/21/20 10:30am revealed: -The staff knows when a resident needs additional assistance by observing them or if the	D 269		

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 269	Continued From page 71	D 269		

resident requests additional assistance.
-The MAs transmit that information to the PCAs verbally during shift report.
-If staff think a resident needs additional assistance, it is reported to the floor supervisor of the resident's floor, who contact the physician or the home health physical therapist.
-It was the floor supervisor responsibility to make sure the care plans for the residents were up to date and follow up with the physicians if their level of care has changed.
-It is the floor supervisor's responsibility make sure the care plan needs for the residents are communicated to the MAs and PCAs.

Telephone interview with the Administrator on 09/29/20 at 2:35pm revealed:
-Residents are assessed by an outside agency RN before admission.
-If the staff determine a resident has had a significant change, the MA/Floor supervisor would contact the physician.
-The MA/Floor Supervisor on the resident's floor, or the Resident Care Coordinator (RCC) whose position is unfilled at this time, would send a revised care plan to the physician for his signature.
-Care needs of the residents are communicated to the staff through service plans, care plans and stand up meetings.
-She was not aware of the "Aide Weekly Task Schedule" the PCAs referred to located at the nurses station in a binder.
-She was not aware the last entry on the task schedule was 07/08/20-07/13/20.

_____

The facility failed to provide personal care assistance regarding Resident #2 not receiving catheter care with leakage and redness to the supra pubic site, and personal care with showers

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D 269	Continued From page 72 and general hygiene; Resident #9 who room smelled of urine, found in a saturated brief had multiple falls resulting in skin tears which eventually became stage 2 decubitus wounds; Resident #1 who tested positive for COVID-19 becoming weak and requiring assistance from staff for personal care and bathing and went 14 days without a bath; Resident #7 bathing, grooming and dressing assistance for a resident who wore the same soiled clothes for several days after staff were prompted that he required extensive assistance; and Resident #17 who had visible dirt on her feet did not receive grooming, bathing, and dressing assistance as indicated in the care plan. The facility's failure to provide personal care resulted in serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 15, 2020 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 30, 2020.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, interviews and record	D 270		

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 270	Continued From page 73	D 270		

reviews the facility failed to provide supervision for 1 of 4 residents (Resident #9) who had a decline in mobility and was found with multiple bruising to her head and hip and skin tears to her hip, arm and elbows.

The findings are:

Review of the facility's fall policy revealed:
-The policy aims to provide guidance to residents and staff on fall prevention and education steps to take when a fall occurs and actions for proper reporting.
-When a fall occurs an incident report will be completed.
-Process for what to do after a fall occurs will be on a case to case basis.

Review of the Personal Care and Supervision of residents facility's document revealed:
-It was crucial that immediately following a fall prompt and appropriate care was forth coming.
-Inappropriate response or action could delay the treatment and could cause further harm to person or injury to the care staff.
-Fall response; ensure the accident had been reported.
-Whenever possible, it is important to explore what may have caused the fall form occurring.
-Continue to observe resident if he/she was not sent to the hospital.
-Head trauma, broken bones, or spinal damage suspected, do not move the person. Call 911.

Incident reports were requested for Resident #9 on 09/15/20 at 9:45am, on 09/21/20 at 12:08pm and on 09/22/20 at 5:55pm, there were no incident reports made available to the survey team for review.

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D 270	Continued From page 74	D 270		

Review of Resident #9's current FL2 dated 03/03/20 revealed:
-Diagnoses include dementia, diabetes, hypertension and anxiety.
-Resident #9 was ambulatory.

Review of Resident #9's care plan dated 05/09/20 revealed:
-Resident #9 was ambulatory with the use of a walker.
-Documentation activities of daily living (1) supervision was required for ambulation and transfers.

Review of Resident #9's physical therapy (PT) notes dated 08/31/20 revealed:
-Resident #9 was found in her room sitting in chair; lethargic and required physical assistance to awaken.
-"There were no care staff on the floor."
-PT assisted Resident #9's with eating, "food tray was not touched."
-Required max- assistance to keep Resident #9 awake.
-The findings were reported to the Administrator the Infectious Disease Manager.
-Resident #9 required physical assistance for all transfers.
-PT notified the primary care physician (PCP) Resident #9 declined in function and was lethargic.

Review of Resident #9's Home Health (HH) nurses notes dated 09/01/20 revealed:
-The HH nurse had seen Resident #9 due to altered mental status.
-Resident #9 was "lethargic and barely speaking."
-Resident #9 required 2-person assistance to move from chair to bed.
-Resident #9 had generalized muscle weakness.

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 270	Continued From page 75	D 270		

-The nurse obtained a urine specimen for a culture.
-Education was provided to the staff for supervision.

Review of Resident #9's Home Health (HH) nurses notes dated 09/03/20 revealed:
-Resident #9 had dementia and required 24 hours supervision and was a one person assist.
-Education was proved to the facility staff on the importance of supervision due to Resident #9 dementia.
-Transfer should only be done with another person to prevent falls.
-Resident #9 had altered mental status more than usual.

Review of Resident #9's facility care notes revealed:
-On 09/03/20 at 9:00am Resident #9 was seen on the floor without injuries. The Power of Attorney (POA) was called. Vital signs were obtained: B/P 136/87, pulse 91, respirations 18 and temperature 97.3.
-On 09/07/20 at 8:22am Resident #9 had bruising to the forehead and right arm. Vital signs were obtained; B/P 166/76 and temperature 98.1.
-On 09/07/20 at 2:32pm the personal care aide (PCA) noticed Resident #9 had bruising on the right hip with skin tear on right shoulder.

Telephone interview with a medication aide (MA) on 09/28/20 at 1:15pm revealed:
-The facility policy was if a resident fell an incident report was to be completed: if the resident hit their head they were to be sent to the emergency room (ER) for an evaluation.
-Resident #9 required 2-person assist with transfers.
-She had worked on 09/03/20 when Resident #9

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D 270	Continued From page 76 was found on the floor in her room. -Resident #9 was found on her knees. -Resident #9 did not have any injuries, skin tears or bruising. -The MA and the PCA placed Resident #9 back in her bed. -She contacted Resident #9's PCP and the family. -She completed an incident report on 09/03/20 and placed the report in Resident #9's record. -She made the Administrator aware of the fall on 09/03/20 without injury. -She reported to the next shift Resident #9 had fallen on 09/03/20 without injury. -She again worked on 09/07/20 when the PCA noticed Resident #9 had bruising and skin tears to her right shoulder, right hip, and her forehead. -She informed the Administrator and the MA/Floor Supervisor on 09/07/20 of the bruising and the skin tears and had them look at Resident #9's skin tears and bruising. - "No one knows what happened to [Resident #9]. -There was no documentation Resident #9 had fallen between 09/03/20 and 09/07/20. -There was no increase in supervision or 15 minute check provided by the staff for Resident #9. -She contacted Resident #9's PCP on 09/07/20 to inform him of the bruising and skin tears. -The PCP ordered a skull x-ray series and a right hip x-ray. -She had ordered Resident #9's x-ray STAT because she was worried something was wrong. -She completed an incident report for Resident #9 on 09/07/20 because of the injury to the head, hip and the shoulder. -She placed the report in Resident #9's record. - "It bothers me that [Resident #9] had all those bruises, she was not like that when I left on 09/03/20."	D 270		

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 270	Continued From page 77 -Resident #9's x-ray for the skull and the hip were negative. Interview on 09/15/20 at 1:42pm with a PCA revealed: -She checked on residents in the facility every 2 hours. -She was never told to check on Resident #9 more than any other resident. -Resident #9 required 2-person assistance with getting out of bed. -Resident #9 could get in the wheel chair but " physical therapy (PT) would get her up." -The MAs and the Administrator knew about Resident #9's bruising, skin tears and the wounds. -She did not know how Resident #9 acquired the brusing to her head and hip or the skin tears. Telephone on 09/17/20 at 11:35am interview with the HH nurse revealed: -Staff had not called her for falls related to Resident #9's bruising on her head, hip, or shoulder or the multiple skin tears. -She was made aware by the HH PT Resident #9 had skin tears and bruising on 09/08/20 when HH PT saw Resident #9 in the facility. -On 09/08/20 the MA told her Resident #9 had fallen, and had bruising to her right hip, left shoulder and forehead. -The facility staff and the Administrator were given education for increase supervision due to Resident #9's dementia and the decrease mental status. Interview on 09/21/20 at 2:25pm with the Administrator revealed: -Resident #9 was bedbound and required more care. -The staff were to make rounds and check	D 270		

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 270	Continued From page 78	D 270		

Resident #9 every 2 hours.
-There was no increase of supervision for Resident #9 when she was found on the floor in her room on 09/03/20.
-Resident #9 was never placed on 30-minute checks.
-The HH PT and the HH nurse made her aware Resident #9 had changes in mental status and mobility.
-The MAs and the MA/Floor Supervisors were responsible for completing incident reports.
-She was unsure how Resident #9 received the bruising to her head and skin tears documented on 09/07/20.
-She knew staff had contacted the PCP to obtain X-ray of Resident #9's head and hip.
-She did not provide an incident report or any interventions the facility staff had put in place to prevent Resident #9 from further injury or falls.

Telephone interview with Resident #9's family on 09/17/20 at 9:10am revealed:
-Staff contacted her on 09/03/20 to inform her Resident #9 had fallen in her room but did not have any injuries.
-The staff told her Resident #9 had fallen on her knees.
-On 09/08/20 the staff called and informed her Resident #9 had altered mental status and was going to the ER for an evaluation.
-She was not made aware of the bruising on Resident #9's head, bruising to the right hip with a skin tear or the skin tear and bruising to the right shoulder.
- "To have bruising on her head she had to fall."

Telephone interview with Resident #9's PCP on 09/21/20 at 9:10am revealed:
-She was completing telehealth visits for the residents in the facility due to the COVID-19

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THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 270	Continued From page 79 precautions. -The HH PT reported Resident #9 was declining in her mobility the middle of August 2020. -She was aware Resident #9 required assistance in her ADLs. -She expected the staff to provide supervision and care for Resident #9's needs. - "The staff are untrained and unlicensed." - "I get more information from HH and PT then I do the facility staff." Telephone interview with the Chief Operating Officer (COO) on 09/29/20 at 2:35pm revealed: -If a resident falls and hit their head their are not always sent out to the ER. -The MAs were to check the eMARs to see if the resident is on an anticoagulant. -The MAs were to check for injury. -There was a check list for the MAs to do after a resident falls. -The check list was not provided for review from 09/15/20 until exit 09/29/20. -The MAs were to contact the Administrator prior to sending out residents. -The MAs were to contact the PCP and the POA if a resident fell.	D 270		
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: TYPE A1 VIOLATION Based on observations, interviews and record	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 80	D 273		

reviews the facility failed to ensure referral and followup to health care providers for 5 of 10 sampled residents (Resident #6, #9, #2 #10, and #3) regarding stomach pain, not feeling well, and not eating (Resident #6); a fall with injury to head and hip, multiple wounds and loss of weight (Resident #9); reporting of daily weights with parameters (Resident #2); medication refusals (Resident #10); and reporting of daily weights with parameters (Resident #3).

The findings are:

Review of a sign posted in the facility breakroom on a bulletin board revealed:
-Absolutely no resident shall be sent out of the building without permission from the Administrator.
-Do not call the on-call doctor before calling the Administrator for directions.
-The document was signed by three medication aides (MA).

1. Review of Resident #6's current FL2 dated 06/17/20 revealed:
-Diagnoses included chronic obstructive pulmonary disease (chronic lung disease), Atrial-fibrillation (abnormal heart rhythm), hypertension and history of Takosubo (heart failure).
-Resident was semi-ambulatory and required assistance with bathing.
-She was incontinent of bladder but continent of bowel.

Interview with the Adult Home Specialist from the local County Department of Social Services on 09/15/20 at 8:30am revealed:
-A friend of Resident #6 had contacted the office with a concern regarding the facility and Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 81	D 273		

#6 care.
-The friend had spoken to Resident #6 multiple times in September 2020 while she resided at the facility and prior to her hospital admission 09/12/20.

Review of Resident #6's care notes revealed:
-On 09/09/20 at 2:00pm Resident #6 requested "a sick tray" for supper. She stated, "her ulcer was bothering her and it acts up from time to time."
-Resident #6 requested broth because it "usually helps her."
-On 09/12/20 at 8:30pm Resident #6 stated "her ulcer and hernia in her belly was bothering her."
-She did not feel well and requested to go the emergency room (ER) 09/12/20.
-Vital signs were documented B/P 92/55, Respirations 17, Temperature 97.2, oxygen saturation 93 and heart rate 92.
-The family and physician were called.

Review of Resident #6's ER physician notes dated 09/13/20 revealed:
-Resident #6 completed the questions for the history and physical assessment.
-Resident #6 chief complaint was nausea and vomiting for 2 weeks; she had not eaten since last Friday and kept throwing up. Resident #6 had complained of abdominal pain off and on for 2 weeks more on the right side.
-Resident #6 reported constipation but the stools then became more loose until she was having diarrhea.
-Resident #6 was spitting up clear liquids.
-The computed tomography (a diagnostic imaging test) (CT) of the abdomen and pelvis revealed ascending colonic mass with possible ruptured, metastatic liver lesions; recommendation of surgery consult.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 82 Observation of Resident #6 in the local hospital on 09/15/20 at 3:10pm revealed: -The family and the Adult Home Specialist were present in the room during the visit. -Resident #6's head of bed was elevated to a 90-degree angle. -She was pale and non-verbal but raised her eye lids when spoken to. -Her stomach was distended. Interview with a medication aide (MA) on 09/15/20 at 11:15am revealed: -She knew Resident #6 was "not feeling well" on 09/09/20. -Resident #6 was not eating much. -She administered Imodium (used to decrease diarrhea) to Resident #6 on 09/09/20. -The Imodium helped Resident #6's stomach. -She had not contacted the provider Resident #6 was not eating much and was not feeling well. Review of Resident #6's September 2020 electronic medication administration record (eMAR) revealed there was no entry or documentation Imodium had been administered on 09/09/20 or from 09/01/20 to 09/15/20. Interview with a personal care aide (PCA) on 09/16/20 at 3:00pm revealed: -She worked with Resident #6 on 09/11/20 and on 09/12/20. -Resident #6 was laying around and was not her usual self. -Resident #6 laid in bed and covered her head with the bedcovers. -Usually Resident #6 was in her wheelchair. -Resident #6 requested a sick tray on both days. -A sick tray consisted of broth and liquids. -She reported to the MA Resident #6 was not	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 273	Continued From page 83	D 273		

feeling well and not eating on 09/11/20.
-She was not sure if the MA called Resident #6's physician.

Interview with another PCA on 09/17/20 at 3:05pm revealed:
-She had worked on 09/10/20.
-Resident #6 complained of stomach pain.
-Resident #6 had laid in bed all day, "she was not feeling well."
-Resident #6 was "not eating much."
-She had told the MA on 09/10/20 Resident #6 was not feeling well.

Interview with a MA/Floor Supervisor on 09/15/20 at 10:40am revealed:
-On 09/09/20 she noticed Resident #6's eating pattern had changed.
-Resident #6 requested broth to eat for 2 days.
-She said her "ulcer was acting up."
-On 09/12/20 she requested cereal for breakfast and not her regular meal.
-Resident #6 said her "hernia was bothering her."
-She had not contacted the provider to report Resident #6 was not eating much or complained of her ulcer acting up.
-Saturday (09/12/20) after the medication pass Resident #6 requested to go the ER around 9:00pm.
-She sent Resident #6 out to the ER on 09/12/20 because she complained of stomach pain.

Interview with a second MA on 9/18/20 at 8:35am revealed the MAs have to get approval from the Infection Control Manager and the physician before we can send residents out to the hospital, but there was no reason for it to be denied.

Interview with a third MA on 9/18/20 at 9:18am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 273	Continued From page 84 -It depended on what the issue was if someone had to give approval for residents to be seen by the PCP or to go to the hospital. -When a resident fell the MAs checked to see if they hit their head, check vital signs, do a complete body scan and notify the provider. -The falls were to be documented and reported to the Administrator or the on-call physician. Interview with Resident #6's family member on 09/15/20 at 3:10pm revealed: -He was not aware Resident #6's had a ulcer or hernia. -Resident #6 called last week and asked him to bring her some pepto-bismol (used for gas relief) and crackers. -The facility contacted him on 09/12/20 Resident #6 was complaining of stomach pain. Telephone interview with a friend of Resident #6 on 09/18/20 at 10:24am revealed: -Resident #6 had called her and said she had not eaten in 8 days. -Resident #6 knew she was sick. -Resident #6 told her the staff at the facility came into her room and said, so you want to see a doctor in the hospital. Telephone interview with Resident #6's second friend on 09/17/20 at 11:30am revealed: -He contacted the Department of Social Services (DSS) and spoke to the AHS on 09/14/20. -Resident #6 had called him on 09/07/20 prior to going into the hospital. -Resident #6 complained of not feeling well and not eating much since 09/04/20. -On 09/09/20 Resident #6 called and told him she wanted to go the hospital. -She had told the staff she wanted to go to the hospital and the Administrator came to Resident	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 273	Continued From page 85	D 273		

#6's room to look at her, the Administrator told Resident #6 she did not need to go the hospital.
-Resident #6 was sick for over a week and the facility would not send her out.
-He called Resident #6 in the hospital on 09/14/20 and spoke to her.

A second telephone interview with Resident #6's family member on 09/18/20 at 10:15am revealed:
-He walked into Resident #6's hospital room and over-heard Resident #6 talking on the phone.
-Resident #6 was talking to someone, she said they would not let her go the hospital.
-He did not know who she was talking to and did not think to question Resident #6 about it.

Interview with the Administrator on 09/16/20 at 11:00am revealed:
-She was not a nurse.
-The staff had reported to her Resident #6 was not eating.
-She had gone to Resident #6 room on 09/09/20 to see her.
-Resident #6 said, "she was ok."
-Resident #6 said, "I am fine."
-Resident #6 told the Administrator she "could not keep anything down."
-Resident #6 told the Administrator she did not have a sore throat.
-Resident #6 told the Administrator it was her hernia acting up.
-On 09/10/20 she had seen Resident #6 again in her room.
-Resident #6 said she ate all her breakfast and requested soup for lunch.
-On 09/11/20 Resident #6 told her she was constipated.
-On 09/12/20 she saw Resident #6 again and she requested soup for lunch.
-The MAs were responsible for contacting the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 273	Continued From page 86	D 273		

provider for any change in condition, but she did not think Resident #6 had a change in condition.

Review of Resident #6 hospital discharge dated 09/16/20 revealed:
-Resident #6 CT showed a ascending colonic mass with possible ruptured, and metastatic liver lesions.
-Resident #6 was admitted to intensive care unit.
-Resident #6 was told of the CT findings.
-She declined to tell her family of the CT results, but requested to talk to a facility staff person.
-The ER physician called the facility and requested to talk that staff person.
-The ER physician was placed on hold for 30 minutes.
-The staff at the facility could not locate the staff person Resident #6 requested to talk to.

Telephone interview with Resident #6's physician office nurse on 09/22/20 at 10:15am revealed:
-Resident #6 was seen in the office by one of the physicians.
-There was no documentation the facility had contacted the office on 09/09/20 through 09/22/20.
-She nor the office was made aware Resident #6 complained of not eating, stomach pain, or not feeling well.
-She thought the facility should have contacted the office after 24 hours of Resident #6 not eating or not feeling well.
-If the facility would have contacted the office the physician would at the least requested to see Resident #6 in the office.
-The physician would want to know about any change in Resident #6's condition.
-If Resident #6 was not eating she could have been weak and became dehydrated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 273	Continued From page 87	D 273		

Review of Resident #6's hospital notes dated 09/16/20 revealed Resident #6 died on 09/16/20 while in the hospital.

2. Review of Resident #9's current FL2 dated 03/03/20 revealed diagnosis include dementia, diabetes, hypertension and anxiety.

a. Review of Resident #9's current FL2 dated 03/03/20 revealed
-Resident #9 was ambulatory.
-Resident #9 was incontinent of bowel and bladder.

Review of Resident #9's facility care notes revealed:
-On 09/03/20 at 9:00am Resident #9 was seen on the floor without injuries. The Power of Attorney (POA) was called. Vital signs were obtained: B/P 136/87, pulse 91, respirations 18 and temperature 97.3.
-On 09/07/20 at 8:22am Resident #9 had bruising to the forehead and right arm. Vital signs were obtained; B/P 166/76 and temperature 98.1.
-On 09/07/20 at 2:32pm the Personal Care Aide (PCA) noticed Resident #9 had bruising on the right hip with skin tear on right shoulder.
-On 09/08/20 Resident #9 was found unresponsive by the Home Health (HH) nurse. Vital signs were temperature 98.2, pulse 125, respirations 18, B/P 156/46. Family and physician were notified.

Review of Resident #9's HH Physical Therapy (PT) notes dated 09/08/20 revealed:
-Resident #9 was lying in bed.
-She had bruising to her forehead, left shoulder, right hip, and skin tears to her right shoulder, right elbow and right hip.
-The staff reported they found Resident #9 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 88	D 273		

09/07/20 with bruising to her head and hip.
-Staff contacted the Primary Care Provider (PCP) and obtained orders for a skull and hip x-rays.
-The x-ray were negative.
-There were no reported falls documented in Resident #9's record for PT to review.

Review of Resident #9's record revealed a physician order dated 09/07/20 for a skull series and a right hip X-ray (STAT) portable due to limited mobility.

Telephone interview with HH Physical Therapist on 09/16/20 at 3:10pm revealed:
-She had seen Resident #9 in the morning on 09/08/20.
-She was concerned about Resident #9's bruising and skin tears.
-She asked the staff what happened to Resident #9 but the staff did not know what caused the bruising and skin tears to Resident #9.
-The PT informed the HH nurse of Resident #9's condition on 09/08/20.

Review of the HH nurse notes dated 09/08/20 revealed:
-She had seen Resident #9 in the afternoon on 09/08/20.
-Resident #9 "fell over the weekend."
-Resident #9 had brusing to her forehead, "scattered brusing all over" and skin tears to her right shoulder and right hip.
-No one reported the fall to her until 09/08/20.
-Resident #9 had "been in bed all weekend."
-She walked into Resident #9's room, Resident #9 was sitting in the wheelchair "facing the bed with her head all the way back."
-Resident #9 was "unresponsive, clammy and cold" and her heart rate was irregular.
-Resident #9's "pupils were fixed."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 89	D 273		

-The HH nurse called for the HH PT to assist, the PT called the Administrator.
-Resident #9 was sent out to the ER.

Telephone interview with the HH nurse on 09/17/20 at 11:35am revealed:
-She had seen Resident #9 on 09/08/20 in the afternoon.
-She was not informed of Resident #9's bruising to her head and hip or the skin tears until 09/08/30.
-She was told by a MA Resident #9 fell but there was no documentation in the record of a fall.
-The HH PT made her aware Resident #9 had bruising to her forehead the morning of 09/08/20.
-Resident #9 was found unresponsive and was sent out to the ER for evaluation.
-She or the office were never contacted for injury resulting in the head trauma.

Telephone interview with Resident #9's PCP on 09/21/20 at 9:10am revealed:
-The facility contacted her on 09/03/20 to inform her that Resident #9 had fell on her knees and did not have any injury.
-She asked the staff if Resident #9 had hit her head, staff had informed her no.
-She was not aware Resident #9 had bruising to her head or hip until the facility contacted the physician on 09/07/20 to obtain x-rays for Resident #9's hip and skull.
-She expected the staff to contact her when a resident fell and hit their head.
-If she would had known Resident #9 had fallen and hit her head she would have sent her out to the ER.
-"I get more information from HH then I do the facility."

Review of Resident #9's hospital discharge dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 90	D 273		

09/12/20 revealed:
-Upon arrival to the facility EMS found Resident #9 weak and in "some respiratory distress."
-Resident #9 was admitted with a diagnosis of cardiac arrhythmia.
-Resident #9 was started on antibiotics ceftriaxone and flagyl to cover the possible intraabdominal infection.
-Resident #9 was admitted to the hospital for further testing.
-Resident #9 tested positive for COVID-19.

Telephone interview with a medication aide (MA) on 09/28/20 at 1:15pm revealed:
-The facility policy was if a resident fell an incident report was to be completed: if the resident hit their head they were to be sent to the emergency room (ER) for an evaluation.
-Resident #9 required 2-person assist with transfers.
-She had worked on 09/03/20 when Resident #9 was found on the floor in her room.
-Resident #9 was found on her knees.
-Resident #9 did not have any injuries, skin tears or bruising.
-The MA and the PCA placed Resident #9 back in her bed.
-She contacted Resident #9's physician and the family.
-She completed an incident report on 09/03/20 and placed the report in Resident #9's record.
-She reported to the next shift Resident #9 had fallen without injury.
-She again worked on 09/07/20 when the PCA noticed Resident #9 had bruising and skin tears to her right shoulder, right hip, and her forehead.
-She informed the Administrator and the MA/floor supervisor of the bruising and the skin tears and had them look at Resident #9's skin tears and bruising.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 91	D 273		

- "No one knows what happened to [Resident #9].
-There was no documentation Resident #9 had fallen.
-She contacted Resident #9's physician to inform him of the bruising and skin tears.
-The physician ordered a skull x-ray series and a right hip x-ray.
-She ordered Resident #9's x-ray STAT because she was worried something was wrong.
-She completed an incident report for Resident #9 on 09/07/20 because of the injury to the head, hip and the shoulder.
-She placed the report in Resident #9's record.
-She did not know what happened to Resident #9's incident reports after she completed both of them on 09/03/20 and on 09/07/20.
-"It bothers me that [Resident #9] had all those bruises, she was not like that when I left on 09/03/20."
-Resident #9's x-ray for the skull and the hip were negative.

Incident reports were requested from the Administrator for Resident #9 on 09/15/20 at 9:45am, on 09/21/20 at 12:08pm and on 09/22/20 at 5:55pm. There were no incident report made available to the survey team for review.

Telephone interview with Resident #9's family on 09/21/20 at 8:07pm revealed:
-The facility called her on 09/03/20 and reported finding Resident #9 on the floor in her room on her knees.
-The staff told her Resident #9 did not have any injuries.
-She did not know Resident #9 had bruising to her head and hip or of the skin tears.
-She did not know Resident #9 required a skull x-ray and a hip x-ray on 09/07/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 92 Interview with the Administrator on 09/21/20 at 2:25pm revealed: -She was not a nurse. -She could not recall the sign posted in the staff breakroom to call her prior to sending out a resident to the ER. -She was unsure how Resident #9 received the bruising and skin tears documented on 09/07/20. -She did not know how Resident #9 had sustained bruising to her forehead. -She expected staff to contact the PCP for any changes in condition or injury to any resident. -She was aware staff contacted the physician to obtain x-rays for Resident #9's hip and skull on 09/07/20. -She could not provide Resident #9's incident/accident report for review or a facility fall assessment, or any intervention put in place to prevent further falls from occurrences. -She relied on her staff to report all falls to her. Telephone interview with the temporary Administrator and the chief operating officer (COO) on 09/29/20 at 1:15pm revealed: -The MAs were responsible for notifying the MA/floor supervisors and they would notify the PCP. -The MA/ floor supervisor would be responsible for notifying the physician of any changes. b. Review of Resident #9's current FL2 dated 03/03/20 revealed skin was normal. Observation of Resident #9 on 09/15/20 at 1:42pm revealed: -Resident #9 was laying in the bed on her back, she was nonverbal. -There was a dark greenish-blue bruise to the middle of her forehead approximately 2 inches long and 1 inch wide.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 93	D 273		

-There was dark blue bruising to both forearms and hands.
-There was dressing to her right shoulder.
-There was a dark red circular area to her right hip approximately 3 inches long and 2 inches wide. In the center of the dark red area was a wound approximately 1.5 x 1 inch. The wound had blackish-brown thick tissue with a white-yellowish tissue border around the wound.
-There were 3 circular red areas each approximately 1 inch to her sacral region; 1 area directly in the middle of her sacral near the coccyx and 2 on each side of the coccyx.
-Resident #9's brief was saturated with yellowish-dark urine.
-Her peritoneal area was reddened as well as her upper inner thigh.

Review of Resident #9's HH PT notes dated 09/08/20 revealed:
-Resident #9 was laying in her bed.
-She had bruising to her forehead, left shoulder, right hip, skin tears to her right shoulder,elbow and hip.
-The MA said she found Resident #9 that way on 09/07/20.
-The MA had called the PCP to inform her of Resident #9's bruising and skin tears.
-The PCP ordered x-ray of the head and the hip.
-The X-rays were negative for fractures.
-The Administrator was made aware of Resident #9's brusing and skin tears.
-PT had contacted the PCP on 09/08/20 to inform her of Resident #9's bruising and the skin tears.

Review of the HH nurse notes dated 09/08/20 revealed:
-She had seen Resident #9 in the afternoon on 09/08/20.
-Resident #9 had brusing to there forehead and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 94	D 273		

"scattered brusing all over" and skin tears to her right shoulder and right hip.
-Resident #9 had "been in bed all weekend."

Telephone interview with the HH nurse on 09/17/20 at 11:35am revealed:
-Resident #9 had dementia.
-She was not informed of Resident #9's bruising to her head and hip or the skin tears until 09/08/20.
-She was told by a MA on 09/08/20 Resident #9 fell, but there was no documentation in the record of a fall.
-The HH PT made her aware Resident #9 had bruising to her forehead the morning of on 09/08/20.
-She had seen Resident #9 when she returned from the hospital on 09/14/20 for wound care.
-She had assessed Resident #9's wound to the right hip and the right shoulder.
-She was not aware of the 3 reddened areas to Resident #9 sacral region.
-She provided education to the staff and encouraged turning and repositioning to prevent further skin breakdown.

Observation of Resident #9 in her room on 09/18/20 at 10:26 am revealed:
-Resident #9 was lying in bed on her back.
-Resident #9 had a dressing to her right hip.
-There was a reddened area approximately 4 X 4 inches on Resident #9's right hip that had a white cream over it.
-The sacral area had a large redden area that had a smaller open excoriated wound, there was no dressing or cream over the sacral wound.
-There was a quarter size reddened area to the left hip with a white cream over the area.

Telephone interview with Resident #9's Primary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 95	D 273		

Care Provider (PCP) on 09/16/20 at 9:10am revealed:
-The facility contacted her on 09/03/20 that Resident #9 had fell on her knees and did not have any injury.
-She was not made aware of Resident #9's wounds to her sacral area.
-She was made aware of the wound to Resident #9's right hip by the HH nurse on 09/14/20.
-She expected the facility to report all wounds and any other issue to her so she could treat the resident accordingly.

Telephone interview with Resident #9's family on 09/21/20 at 8:07pm revealed:
-The facility called her on 09/03/20 and reported finding Resident #9 on the floor in her room on her knees.
-The staff told her Resident #9 did not have any injuries.
-The facility did not make her aware Resident #6 had wounds to her hip, shoulder or sacral area.
-On 09/18/20 the ER physician called with concerns of the wounds on Resident #9's right hip, right shoulder and the sacral area.

Interview with the Administrator on 09/21/20 at 2:25pm revealed:
-She was unsure how Resident #9 received the bruising and skin tears documented on 09/07/20.
-Staff were to contact the PCP for any change in condition or injury to any resident.
-The HH nurse was treating Resident #9's wounds as of 09/14/20.
-She was not aware of the sacral wound until the survey team informed the Infectious Disease Manager during the observation of Resident #9 wounds on 09/15/20.
-She had not seen Resident #9's wounds, "that is out of my scope".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 96 Review of Resident #9's ER note date 09/18/20 revealed: -Reason for admission was altered mental status and lactic acidosis and elevated white blood count. -Resident #9 was lethargic. -Resident #9 was administered lactated ringers to improve hydration and cefepime (an antibiotic) intravenously (IV) as well as vancomycin (an antibiotic) IV for the possibility of sepsis. -Documentation Resident #9 had decubitus on her right shoulder, right hip and sacrum which were all stage 2. -Resident #9 was admitted to the hospital for evaluation. c. Review of Resident #9's current FL2 dated 03/03/20 revealed: -Resident #9 was ambulatory. -Resident #9 was incontinent of bowel and bladder. -Medications included diabetic supplement shakes 1 can two times daily. Review of Resident #9's care plan dated 05/09/20 revealed eating was (2) limited assistance, cut meats. Review of the facility monthly vital signs document for Resident #9 from March 2020 through September 2020 revealed: -On 03/16/20 Resident #9's weight was documented as 125.4lbs. -On 04/13/20 Resident #9's weight was documented as 127.3lbs. -On 05/04/20 Resident #9's weight was documented as 126.6lbs. -On 06/01/20 Resident #9's weight was documented as 122.1lbs.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 97	D 273		

-On 07/06/20 Resident #9's weight was documented as 119.8lbs.
-On 08/03/20 Resident #9's weight was documented as 120lbs.
-On 09/07/20 Resident #9's weight was documented as 116.8lbs.
-From March 2020 through September 2020 Resident #9 had a total weight loss of 8.6 lbs.

Review of Resident #9's hospital discharge on 09/12/20 revealed Resident #9's weight was 52.7kg (116.18lbs).

Review of Resident #9's hospital discharge on 09/18/20 revealed:
-Resident #9's weight was 50.3kg (110.89lbs).
-Resident #9 was discharged to a skilled nursing unit.

Review of Resident #9's physical therapy (PT) notes dated 08/31/20 revealed:
-Resident #9 was found in her room sitting in chair; lethargic and required physical assistance to awaken.
-PT assisted Resident #9's with eating, "food tray was not touched."

Observation of Resident #9 on 09/18/20 at 9:43am revealed:
-She was in her room lying in bed tilted to her left side.
-Her breakfast tray was on the bedside table and was untouched.

Interview with a medication aide (MA) on 09/21/20 at 9:35am revealed Resident #9 required feeding and was totally dependent on staff.

Telephone interview with Resident #9's Primary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 98	D 273		

Care Provider (PCP) on 09/16/20 at 9:10am revealed:
-Her visits were telehealth only, she was not allowed in the facility.
-She was not allowed in the facility because she visited other facilities and the facility where Resident #9 resides had COVID-19 positive residents.
-She was not made aware of Resident #9's weight loss.
-She relied on the staff to inform her of Resident #9's weights, "It was hard to get any information from the staff."

Interview with the Administrator on 09/21/20 at 2:25pm revealed:
-The staff were to feed Resident #9.
-The MAs and the MA/floor supervisors were to report any changes in condition to her.
-Staff had not reported any changes in Resident #9's care to her.

Telephone interview with Resident #9's family on 09/21/20 at 8:07pm revealed:
-Resident #9 was taken to the ER on 09/18/20.
-The ER physician called and informed her of Resident #9's weight of 110lbs.
-Resident #9 weight was normally 130 or 135lbs.
-"It brought me to tears to find out my [Resident #9] had loss that much weight."
-"I cannot believe the facility never told us my [Resident #9] was not eating and losing weight."

Attempted interview with Resident #9 on 09/15/20 at 1:42pm revealed Resident #9 was not interviewable.

3. Review of Resident #2's current FL2 dated 05/01/20 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 99	D 273		

-Diagnoses included atrial fibrillation, congestive heart failure, urinary retention, degenerative joint disease and depression.
-There was an order to check weight daily and notify the physician if there was a 3-pound weight gain in 24 hours or a 5-pound weight gain in one week.
-There was an order for Lasix 20mg, take 1 tablet as needed for weight gain of 2-3 pounds in 24 hours.

Review of Resident #2's Care Plan dated 01/15/20 revealed the resident was totally dependent (4) for daily weight checks.

Review of Resident 2's July 2020 electronic medication administration record (eMAR) revealed:
-There was an entry to check weights daily. Notify the provider if there was a 3-pound gain overnight or a 5-pound gain in 1 week.
-Resident #2's weight was documented on 07/04/20 as 134 pounds.
-Resident #2's weight was documented on 07/05/20 as 165 pounds.
-There was no electronic documentation the weight was retaken, or the provider was notified.
-Resident #2's weight was documented on 07/11/20 as 133 pounds.
-Resident #2's weight was documented on 07/12/20 as 163 pounds.
-There was no electronic documentation the weight was retaken, or the provider was notified.
-Resident #2's weight was documented on 07/17/20 as 132 pounds.
-Resident #2's weight was documented on 07/18/20 as 163 pounds.
-There was no electronic documentation the weight was retaken, or the provider was notified.
-Resident #2's weight was documented on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 100	D 273		

07/26/20 as 120 pounds.
-Resident #2's weight was documented on 07/27/20 as 133 pounds.
-There was no electronic documentation the weight was retaken, or the provider was notified.
-There was an entry for Lasix 20mg take 1 tablet as needed for weight gain of 2-3 pounds in 24 hours.
-There was no documentation Lasix 20mg was administered from 07/01/20 through 07/31/20.

Review of Resident #2's July 2020 progress notes in the resident's record revealed there was no documentation the primary care provider (PCP) was notified of weights beyond the ordered parameters.

Review of Resident #2's August 2020 eMAR revealed:
-There was an entry for check weights daily. Notify the provider if there was a 3-pound gain overnight or a 5-pound gain in 1 week.
-Resident #2's weight was documented on 08/01/20 as 133 pounds.
-Resident #2's weight was documented on 08/02/20 as 162 pounds.
-There was no electronic documentation the weight was retaken, or the provider was notified
-Resident #2's weight was documented on 08/10/20 as 130 pounds.
-Resident #2's weight was documented on 08/11/20 as 134 pounds.
-There was no electronic documentation the physician was notified.
-Resident #2's weight was documented on 08/15/20 as 134 pounds.
-Resident #2's weight was documented on 08/16/20 as 140 pounds.
-There was no electronic documentation the physician was notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 101	D 273		

-Resident #2's weight was documented on 08/23/20 as 123 pounds.
-Resident #2's weight was documented on 08/24/20 as 133 pounds.
-There was no electronic documentation the physician was notified.
-Resident #2's weight was documented on 08/29/20 as 120 pounds.
-Resident #2's weight was documented on 08/30/20 as 130 pounds.
-There was no electronic documentation the provider was notified.
-There was an entry for Lasix 20mg take 1 tablet as needed for weight gain of 2-3 pounds in 24 hours.
-There was no documentation Lasix 20mg was administered from 08/01/20 through 08/31/20.

Review of Resident #2's August 2020 progress notes in the resident's record revealed there was no documentation the PCP was notified of weights beyond the ordered parameters.

Review of Resident #2's September 2020 eMAR revealed:
-There was an entry for check weights daily. Notify the provider if there was a 3-pound gain overnight or a 5-pound gain in 1 week.
-From 09/01/20 through 09/05/20 weights were not documented.
-There was no reason documented for the missed weights.
-Resident #2's weight was documented on 09/06/20 as 163 pounds.
-Resident #2's weight was documented on 09/09/20 as 131 pounds.
-There was no electronic documentation the weight was retaken.

Review of Resident #2's September 2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 102	D 273		

progress notes in the resident's record revealed there was no documentation the PCP was notified of a weight loss of 32 pounds in three days.

Telephone interview with a medication aide (MA) on 09/23/20 at 2:10pm revealed:
-Resident #2 had an order to weigh herself daily.
-She kept a scale under her bed and used it to weigh herself in her room.
-Resident #2 documented her daily weight on the calendar in her room.
-The MA documented the weight from Resident #2's calendar on the eMARs.
-If the MA noticed the weight was beyond the ordered parameters, the MA notified the PCP and documented the PCP notification in Resident #2's progress notes.
-If the weight documentation on the eMARS from the previous day was greater than a 3 pound increase, the previous entry could be a mistake.
-She did not go back and check Resident #2's weight entered on the eMAR for the prior day or week.
-Resident #2's weight was usually the same every time the MA weighed her in her room.
-Resident #2's weight was always around 160 pounds.

Telephone interview with another MA on 09/23/20 at 2:26pm revealed:
-Resident #2 used her own scale to weigh herself daily which she kept under her bed.
-The MA would read the number on Resident #2's scale as she weighed herself.
-She thought she was supposed to notify the provider if Resident #2 was losing weight.
-When she entered the daily weight on the eMAR she would look back at the previous day's weight.
-She would document in Resident #2's progress

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 103	D 273		

notes and notify the PCP if there was a weight difference beyond parameters.
-If she saw an increase in weight on the eMARS from a previous day that week, she knew that was an error.
-Resident #2 never gained any weight.
-Resident #2 was always around 130 pounds.

Telephone interview with Resident #2 on 09/24/20 at 11:44am revealed:
-She used to weigh herself every day.
-She removed the scale from under the bed and weighed herself.
-She documented the weight on the calendar in her room and the staff could look at it.
-She did not know if the staff looked at the weight entry or not, but it was available for them to review.
-She had not seen the staff copy the weight documentation on her calendar.
-She knew if she weighed 3 pounds or more, she should report it to the staff.
-She forgot what she was supposed to do with that information.
-She had not weighed herself in a long time.

Telephone interview with Resident #2's responsible family member on 09/18/20 at 2:32pm revealed:
-She had spoken to the Administrator back in March of 2020 and informed her that Resident #2 needed more assistance with activities of daily living.
-Resident #2 needed more cueing around activities due to a noticeable cognitive decline since early to mid August.

Telephone interview with Resident #2's PCP on 09/18/20 at 1:45pm revealed:
-She was Resident #2's PCP since July 2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 273	Continued From page 104 -Due to the quarantine of facilities, she has not had a face to face visit with Resident #2. -She knew Resident #2 had orders for weights to be taken daily, and the provider to be notified if the weights exceeded parameters ordered. -She had not been notified of any weights that exceeded 3 pounds overnight or 5 pounds in a week. -She had not been informed Resident #2 had a weight loss of 32 pounds in three days. -Due to Resident #2's diagnosis of atrial fibrillation, weight gain from fluid overload could lead to significant heart failure and hospitalization. -She expected the staff to notify her when Resident #2's weight gain exceeded parameters. Interview with the Administrator on 09/21/20 at 1:15pm revealed: -Resident #2 preferred to take her daily weights independently. -The MAs were responsible for ensuring Resident #2 weighed herself daily, and documented the weight on the eMAR. -The MAs were responsible for informing the MA/Floor Supervisor of a weight change beyond the ordered parameters. -The MA/Floor Supervisor was responsible for contacting and reporting the weight increase to the PCP. -The phone or fax contact with the PCP should be documented in the progress notes. -She did not know Resident #2's documented weights were beyond the ordered parameters and the provider was not notified. 4. Review of Resident #10's current FL2 dated 12/24/19 revealed diagnoses included end stage renal disease (ESRD), hypertension and hypothyroidism.	D 273		

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D 273	Continued From page 105	D 273		

a. Review of Resident #10's record revealed a provider's order dated 12/24/19 for Clonidine 0.1mg, used to treat high blood pressure, to be administered twice a day.

Review of Resident #10's July 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for Clonidine 0.1mg to be administered twice daily at 7:00am and 7:00pm.
-There was documentation Resident #10's Clonidine 0.1mg was refused 25 out of 31 possible opportunities at 7:00am from 07/01/20 through 07/31/20.
-There was no documentation as to the reason for the refusals.

Review of Resident #10's record revealed no documentation in the progress notes that the provider was notified of
his refusals of Clonidine 0.1mg, 25 out of 31 possible opportunities at 7:00am from 07/01/20 through 07/31/20.

Review of Resident #10's August 2020 eMAR revealed:
-There was an entry for Clonidine 0.1mg to be administered twice daily at 7:00am and 7:00pm.
-There was documentation Resident #10's Clonidine 0.1mg tablet was refused 9 out of 31 possible opportunities at 7:00am from 08/01/20 through 08/31/20.
-There was no documentation as to the reason for the refusals.

Review of Resident #10's record revealed:
-There was no documentation in the progress notes the provider was notified of Resident #10's refusals of Clonidine 0.1mg, 9 out of 31 possible opportunities at 7:00am from 08/01/20 through

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D 273	Continued From page 106 08/31/20. Review of Resident #10's September 2020 eMAR revealed: -There was an entry for Clonidine 0.1mg to be administered twice daily at 7:00am and 7:00pm. -There was documentation Resident #10's Clonidine 0.1mg tablet was refused 3 out of 15 possible opportunities at 7:00am from 09/01/20 through 09/15/20. -There was no documentation as to the reason for the refusals. Review of Resident #10's record revealed no documentation in the progress notes the provider was notified of Resident #10's refusals of Clonidine 0.1mg, 3 out of 15 possible opportunities from 09/01/20 through 09/15/20. Attempted interview with Resident #10 on 09/16/20 at 3:15pm and 09/21/20 at 11:00am was unsuccessful. b. Review of Resident #10's record revealed a provider's order dated 12/24/19 revealed an order for Hydralazine HCL 100mg, used to treat high blood pressure, to be administered three times a day. Review of Resident #10's July 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Hydralazine HCL 100mg to be administered three times daily at 7:00am and 4:00pm and 7:00pm -There was documentation Resident #10's Hydralazine HCL 100mg was refused 17 out of 93 possible opportunities. -There was no documentation as to the reason for the refusals.	D 273		

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D 273	Continued From page 107 Review of Resident #10's record revealed no documentation in the progress notes that the provider was notified of Resident #10's refusals of 17 out of 93 possible doses of Hydralazine 100mg from 07/01/20 through 07/31/20. Review of Resident #10's August 2020 eMAR revealed: -There was an entry for Hydralazine HCL 100mg to be administered three times daily at 7:00am and 4:00pm and 7:00pm. -There was documentation Resident #10's Hydralazine HCL 100mg was refused 8 out of 93 possible opportunities from 08/01/20 through 08/31/20. -There was no documentation as to the reason for the refusals. Review of Resident #10's record revealed no documentation in the progress notes that the provider was notified of Resident #10's refusals of 8 out of 93 possible opportunities of Hydralazine 100mg from 08/01/20 through 08/31/20. Review of Resident #10's September 2020 eMAR revealed: -There was an entry for Hydralazine HCL 100mg to be administered three times daily at 7:00am and 12:00pm and 7:00pm. -There was documentation Resident #10's Hydralazine HCL 100mg was refused 7 out of 45 possible opportunities from 09/01/20 through 09/15/20. -There was no documentation as to the reason for the refusals. Review of Resident #10's record revealed no documentation in the progress notes that the provider was notified of Resident #10's refusals of	D 273		

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D 273	Continued From page 108 7 out of 45 possible opportunities of Hydralazine HCL 100mg from 09/01/20 through 09/15/20. Attempted interview with Resident #10 on 09/16/20 at 3:15pm and 09/21/20 at 11:00am was unsuccessful. c. Review of Resident #10's record revealed a provider's order dated 12/24/19 for Metoprolol Tartrate 25mg, used to treat high blood pressure, three tablets by mouth (75mg) to be administered twice daily. Review of Resident #10's July 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Metoprolol Tartrate 25mg, three tablets by mouth, to be administered twice daily at 7:00am and 7:00pm. -There was documentation Resident #10's Metoprolol Tartrate 25mg was refused 9 out of 31 possible opportunities from 07/01/20 through 07/31/20. -There was no documentation as to the reason for the refusals. Review of Resident #10's record revealed no documentation in the progress notes that the provider was notified of Resident #10's refusals of 9 out of 31 possible doses of Metoprolol Tartrate 75mg from 07/01/20 through 07/31/20. Review of Resident #10's August 2020 eMAR revealed: -There was an entry for Metoprolol Tartrate 25mg, three tablets by mouth, to be administered twice daily at 7:00am and 7:00pm. -There was documentation Resident #10's Metoprolol Tartrate 25mg was refused 8 out of 31 possible opportunities from 08/01/20 through	D 273		

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D 273	Continued From page 109 08/31/20, -There was no documentation as to the reason for the refusals. Review of Resident #10's record revealed no documentation in the progress notes that the provider was notified of Resident #10's refusals of 8 doses of Metoprolol Tartrate 75mg from 08/01/20 through 08/31/20. Review of Resident #10's September 2020 eMAR revealed: -There was an entry for Metoprolol Tartrate 25mg, three tablets by mouth, to be administered twice daily at 7:00am and 7:00pm. -There was documentation Resident #10's Metoprolol Tartrate 25mg was refused 4 out of 15 possible opportunities from 09/01/20 through 09/15/20. -There was no documentation as to the reason for the refusals. Review of Resident #10's record revealed no documentation in the progress notes that the provider was notified of Resident #10's refusals of 4 doses of Metoprolol Tartrate from 09/01/20 through 09/15/20. Telephone interview with the Registered Nurse at Resident 10's dialysis center on 09/18/20 at 10:22am revealed: -Resident #10 had dialysis treatments 3 times a week from 9:45am-1:45pm. -Resident #10 had been in treatment since December 2019. -She was not aware that on any treatment day Resident #10 brought medications from the facility to administer after dialysis. -Scheduled medications that were not administered before or during dialysis treatment	D 273		

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D 273	Continued From page 110 should be administered when Resident #19 returned to the facility. Telephone interview with the MA/Floor Supervisor on 09/25/20 at 1:24pm revealed: -Resident #10 went to dialysis treatment three times a week. -The MAs sent his medications with him to administer after dialysis. -The MAs did not document anywhere that Resident #10 had been given his medications to administer at dialysis. -The MAs did not document the medications Resident #10 received were taken while on LOA (leave of absence). -She had not contacted the provider to determine the best policy to administer medications that were scheduled during the time Resident #10 was at dialysis treatment. -The policy for refusals of medications was three times a medication was refused, not consecutively, the MAs document the refusal in the progress notes and contact the provider. Telephone interview with the primary care provider (PCP) on 09/29/20 at 4:35pm revealed: -She had been Resident #10 PCP since July 2020. -She relied on the staff to keep her informed regarding changes or concerns with Resident #10 since she was not able to enter the facility at this time. -She had not been informed by the facility Resident #10 had refused three of his blood pressure medications multiple times over the past 3 months. -Resident #10 had been diagnosed with hypertension and could have serious complications if he was not taking the proper medication and dosage.	D 273		

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D 273	Continued From page 111	D 273		

-My expectation was that the staff would administer medications as ordered and inform me when Resident #10 refused his scheduled medications 2 or more times.

Interview with the Administrator on 09/21/20 at 1:15pm revealed:
-She expected the MAs to administer medications as ordered by the prescribing provider.
-She expected the MAs or the MA/Floor Supervisors to inform the provider if the resident was refusing medications.
-She was not aware of a policy regarding refusals of medications.
-The MA/Floor Supervisors should contact the provider if a resident was out of the facility for ongoing scheduled treatments, and arrange alternate times for administration of medications the resident was not available to receive.

A request was made on 09/21/20 at 2:30pm for the Medication Refusal policy, but was not provided by exit on 09/30/20.

Attempted interview with Resident #10 on 09/16/20 at 3:15pm and 09/21/20 at 11:00am was unsuccessful.

5. Review of Resident #3's current FL2 dated 12/30/19 revealed:
-Diagnoses included allergic rhinitis, gastroesophageal reflux, and obesity.
-There was an order for weights to be checked daily at 6:00am, notify physician for weight gain of 3 pounds in one day or 5 pounds in one week.

Review of Resident #3's physician visit note dated 08/05/20 revealed additional diagnosis included peripheral vascular disease, chronic acquired lymphedema, and venous stasis.

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D 273	Continued From page 112 Review of Resident #3's signed provider's order dated 03/26/20 revealed there was an order for Resident #3's weight to be checked daily at 6:00am, notify the provider for weight gain of 3 pounds in one day or 5 pounds in one week. Review of Resident #3's July 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for weight to be checked daily at 6:00am, notify the provider for weight gain of 3 pounds (lbs) in one day or 5 lbs in one week. -The time listed for the entry was 8:00am. -The weight was not documented 25 out of 31 opportunities. -Weights ranged from 258 lbs to 270 lbs from 07/08/20-07/30/20. -Weights were documented as 258 lbs on 07/08/20 and 07/09/20, 260 lbs on 07/20/20, and 270 lbs on 07/29/20 and 07/30/20. -On 07/14/20, it was documented that the resident refused. Review of Resident #3's August 2020 eMAR revealed: -There was an entry for weight to be checked daily at 6:00am, notify the provider for weight gain of 3 lbs in one day or 5 lbs in one week. -The time listed for the entry was 8:00am. -The weight was not documented 15 out of 31 opportunities. -Weights ranged from 270-310 lbs from 08/03/20-08/30/20. -On 08/11/20, it was documented that the resident refused. -The resident had fluctuations in his weights, some examples include: 273 lbs on 08/09/20, 278 lbs on 08/10/20, 290 lbs on 08/16/20 and 310 lbs on 08/30/20.	D 273		

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D 273	Continued From page 113 Review of Resident #3's September 2020 eMAR from 09/01/20 to 09/10/20 revealed: -There was an entry for weight to be checked daily at 6:00am, notify the provider for weight gain of 3 lbs in one day or 5 lbs in one week. -The time listed for the entry was 8:00am. -The weight was not documented 10 out of 10 opportunities. -The entry was discontinued on 09/11/20. Review of Resident #3's record revealed there was no order to discontinue weights for Resident #3. Review of Resident #3's "care notes" revealed there was no documentation the provider was contacted regarding the resident's weight gain or the inability to obtain weights. Interview with Resident #3 on 09/21/20 at 3:00pm revealed: -Staff were supposed to check his weight daily. - "They haven't checked my weight in a while". -He did not refuse staff when they asked to check his weight. Interview with a medication aide (MA) on 09/21/20 at 3:00pm revealed: -Resident #3 had an order for weights to be checked daily. -Resident #3 refused daily weights frequently. -She thought the weights were going to be discontinued because he refused. -She did not know who discontinued the weights on the eMAR on 09/11/20. -She had not notified the physician that the resident refused daily weights. -She did not know the facility's refusal policy. -She had not noticed a weight gain and had not	D 273		

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D 273	Continued From page 114 notified the physician. Telephone interview with the primary care provider (PCP) for Resident #3 on 09/22/20 at 8:29am revealed: -She became the PCP for Resident #3 in July 2020. -She continued the order for daily weights for Resident #3. -Daily weights were ordered to determine if the resident had any excess in fluid retention. -She would expect to be notified if weights were outside the parameters. -She had not discontinued the order for weights for Resident #3. -No one informed her that Resident #3 had any fluctuations in his weight. -"There is a huge breakdown in communication." -The increase in weight gain would prompt her to order additional medication. -Too much fluid retention could worsen Resident #3's lymphedema including cellulitis. Interview with the temporary Administrator and the Chief Operating Officer (COO) on 09/29/20 at 1:15pm revealed: -She did not know Resident #3's weights were not being done as ordered. -The MAs were responsible for completing weights as ordered. -If the resident was refusing weights, MAs were responsible for notifying the MA/Floor Supervisor and they would notify the PCP. -She expected the provider to be notified if weights were outside of parameters. -The MAs or MA/Floor Supervisors would be responsible for notifying the physician of any changes. The facility failed to provide physician notification	D 273		

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D 273	Continued From page 115 for Resident #6 who complained of stomach pain for 2 weeks, not eating for a week, laid in bed, not feeling well, requested to be sent out to the ER for an evaluation and after several days eventually was sent to the ER, had a CT of the abdomen and pelvis, diagnosed with a colon mass with possible ruptured and metastatic liver, placed on comfort care and died in the hospital 4 days after admission; Resident #9 fell with trauma to head and hip with multiple skin tears, with no knowledge or report of how or when she fell, resulting in two hospital admissions, with stage 2 and 3 decubitus ulcers identified and weight loss of 6 pounds in less than 2 weeks (116 lbs down to 110 lbs); Resident #2 had weight gain beyond parameters that placed her at risk for fluid overload; Resident #10 who was hypertensive and refused 3 of his blood pressure medications multiple times with the refusals not reported to the physician; and Resident #3 whose daily weights were not obtained as ordered and the failure to notify the physician of weight gains, which put the resident at risk for further complications with lymphedema. The facility's failure to provide referral and follow-up with the appropriate medical providers to meet the routine and acute health care needs of residents was detrimental to their health and welfare and constitutes a TYPE A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 15, 2020 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 30, 2020.	D 273		

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D 338	Continued From page 116	D 338		
D 338	10A NCAC 13F .0909 Resident Rights	D 338		

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to practicing infection control procedures to reduce the risk of transmission and infection, including administration of medications following infection control measures, COVID-19 positive staff working with non-COVID-19 residents, screening of staff and essential visitors, practicing social distancing while in the smoking area, and staff wearing appropriate personal protective equipment (PPE) and practicing social distancing requirements.

The findings are:

Review of the CDC guidelines for the prevention and spread of the coronavirus in long-term care (LTC) facilities revealed:
-Personnel should always wear a face mask in the facility.
-Face masks should not be worn under the nose

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D 338	Continued From page 117 or mouth. -Social distancing should be implemented among the residents. -If COVID-19 is identified in the facility, restrict all residents to their rooms. -Residents with known or suspected COVID-19 should be cared for using recommended personal protective equipment (PPE) including eye protection, gloves, gown, and a N95 respirator face mask. -A surgical mask can be used if a N95 mask is not available. -Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly. -Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an Environmental Protection Agency (EPA) registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for coronavirus in healthcare settings. Review of the NCDHHS for prevention and spread of the coronavirus in LTC facilities revealed: -Facility staff should wear appropriate PPE when caring for patients with undiagnosed respiratory infection or confirmed COVID-19. -All facility staff should wear a face mask while in the facility. -Residents with known or suspected COVID-19 should ideally be placed in a private room with their own bathroom. -Symptomatic residents and asymptomatic residents who test positive for COVID-19 should be cohorted in a designated location and cared for by a consistent group of designated facility staff.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 338	Continued From page 118 Review of the Centers for Disease Control (CDC) guidelines for Preparing for COVID-19 in Nursing Homes and Infection Control for Nursing Homes dated 07/25/20 revealed to identify a space in the facility that could be dedicated to the care for residents with confirmed COVID-19. Review of NCDHHS What to Expect: Response to New COVID-19 Cases or Outbreaks in Long Term Care Settings dated 09/04/20 revealed: -Follow NC DHHS and CDC guidance. -Your local health department will guide you on patient placement, cohorting of patients and staff, and environmental cleaning. -Check CDC guidance for the most up-to-date infection prevention recommendations for long-term care settings. Interview on 09/15/20 at 10:47am with the Administrator and the Chief Operating Officer (COO) (via conference call) revealed: -There were initially 26 residents and 4 staff in the facility who tested positive for COVID-19 between 08/21/20 and 08/27/20. -There were 2 more resident cases on 09/09/20 who tested positive at the hospital. -The current census of the facility was 106. Review of the facility's COVID-19 testing spreadsheet revealed there were 25 residents who had tested positive between 08/21/20 and 09/03/20. Telephone interview on 09/22/20 at 1:01pm with the Administrator and the COO revealed: -The were 2 more resident cases of COVID-19 since 09/16/20. -One resident resided on the second floor and the other on the third.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 338	Continued From page 119 -Both residents were still in the hospital. Telephone interview on 09/22/20 at 1:01pm with the Chief Operating Officer (COO) revealed: -The facility had a physician liaison that provided COVID-19 guidance to the facility along with the local health department (LHD). -The physician liaison and the LHD were contacted when the first positive case of COVID-19 was confirmed. Telephone interview with the local LHD Infectious Disease Registered Nurse on 09/17/20 at 1:10pm revealed: -She emailed the COO with recommendation when the first COVID-19 positive case was confirmed in the facility. -Her recommendations were to isolate the positive COVID-19 cases from the other residents for a minimum of 10 days from when symptoms started. -If residents tested COVID-19 positive and no symptoms, they must have no fever for 24 hours without the use of a fever reducer. -The CDC guidelines do not recommend retesting the positive COVID-19 residents due false positive results, because of the virus shedding which could last up to 3 months. -Retesting negative COVID-19 residents every 3-7 days until there were no more positive COVID-19 cases. -If there were any new cases of COVID-19 in the facility she would recommend re-testing the negatives until there were no positive confirmed cases. -She was not aware of any re-testing for COVID-19 completed by the facility. -She did not give guidance for COVID-19 screening, but best practice was for one person to complete the screening.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 338	Continued From page 120 -She did not recommend staff screen themselves for signs or symptoms of COVID-19. 1.Review of the facility's COVID-19 policy revealed: -Community cleaning; The disinfectant that was used would kill COVID-19. The staff were to spray down surfaces that were frequently touched. -Hand hygiene; Staff should perform hand hygiene before and after all resident contact and contact with potentially infectious material. -Staff should perform hand hygiene by using hand sanitizer or washing their hands. Interview on 09/15/20 at 10:45am with the Infection Control Manager (ICM) revealed: -She was also the Marketing Director. -All the COVID-19 positive residents were moved to the 3rd floor on the back hall for monitoring and care. -The front hall of the 3rd floor was COVID-19 negative residents. Confidential interview revealed there was a medication aide (MA) who tested positive for COVID-19 working in the facility who passed medications to the residents. Review of Resident #14's FL2 dated 07/29/20 revealed diagnoses included anxiety, pneumonia, mobility, anemia and muscle weakness. Review of Resident #14's record revealed she tested COVID-19 positive and resided on the 3rd floor. During the medication pass on 09/16/20 between 8:15am and 8:35am on the COVID-19 positive floor there was a breech in infection control	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 338	Continued From page 121	D 338		

procedure. One medication error out of 36 opportunities during the 8:00am medication pass on 09/16/20.

Observation on 09/16/20 of the medication cart on the third floor revealed there was no hand sanitizer on the medication cart.

Observation on 09/16/20 at 8:40am of the medication aide (MA) passing medications on the 3rd floor revealed:
-She applied gloves.
-She opened the drawer on the medication cart and retrieved Resident #14's medications.
-The medications were in a pharmacy generated bubble package.
-She closed the drawer on the medication cart.
-She picked up each bubble pack and verified the medications to the electronic medication administration record (eMAR).
-She touched the computer (eMAR) with her right gloved hand to scroll through and identify each medication for Resident #14.
-Using both gloved hands she held each bubble pack and dispensed a total of 17 pills in a small medication cup.
-She removed Resident #14's inhaler from the medication cart and placed it on the top of the medication cart.
-She removed a nebulizer treatment for Resident #14 from the drawer and placed it on the top of the medication cart.
-When asked to count the medications to verify the medications matched the written amount documented by the surveyor, she poured all the pills from the medication cup into her left gloved hand.
-She picked up one pill at a time using her right gloved hand counting the pills and placing them back into the medication cup for administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 122	D 338		

-One pill dropped out of her gloved right hand and landed on the top of the medication cart.
-The MA picked up the pill using her right gloved hand and placed it into the medication cup with all the other pills and counted 17 pills.
-The MA was stopped by the surveyor due to contamination of the pills from the gloves as well as the contamination from the pill dropped on top of the medication cart.

Interview on 09/16/20 at 8:45am with the MA who performed the medication pass revealed:
-She worked first shift passing medications on the COVID-19 floor on a regular basis.
-She was the only MA passing medications on the third floor on 09/16/20.
-The third floor consisted of COVID-19 positive and COVID-19 negative residents.
-She was not aware why she was stopped by the surveyor prior to administering the medications to Resident #14.
-She wore gloves during her medication pass due to the COVID-19 positive residents on the third floor.
-She did not know when the medication cart was last cleaned.
-She had not cleaned the medication cart prior to her shift on 09/16/20.
-Night shift usually cleaned the medication carts.
-She was not aware there was no hand sanitizer on the medication cart on 09/16/20.
-She never thought the gloves were contaminated after opening the drawers to the medication cart, touching the top of the medication cart, touching the computer (eMAR), or handling Resident #14's pharmacy generated bubble packages.
-She did not know pouring all the pills in her left gloved hands would contaminate the pills.
-When she dropped the pill on top of the medication cart and placed it in the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 123	D 338		

cup with the other pills, she did not know it was contaminated.

Interview on 09/16/20 at 9:00am with the Administrator revealed:
-Third floor was the designated COVID-19 positive floor with the back hallway as the COVID-19 positive side.
-Staff were to have hand sanitizer on all the medication carts in the facility.
-She was not aware the third-floor medication cart did not have hand sanitizer.
-The staff were to clean the medication carts prior to beginning every shift.
-She was not aware the MA on the third floor used the same pair of gloves to dispense medications, open med cart drawers, scroll on the electronic Medication Administration Record (eMAR) computer system and pick up a pill off the med cart.

Interview with Resident #14 on 09/16/20 at 9:35am revealed:
-She tested positive for COVID-19 about 3 weeks ago.
-The MA that worked on 09/16/20 had worked on the third floor passing medications multiple times.
-All the staff wore PPE which include gloves, gowns, masks and face shields.
-The MAs wore PPE when entering her room to administer her medications.
-The MAs brought the mediations into her room in a medication cup.
-The medication cup was given to her and she took the pills about 3 at a time with water.
-She never saw the MAs change gloves before or after entering her room.

Interview on 09/22/20 at 8:20pm with a second shift MA revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 338	Continued From page 124 -She passed medications, performed personal care, and cleaned. -She cleaned the medication cart once or twice a week using a disinfectant. 2. Review of the Centers for Disease Control (CDC) guidelines for Repeat Testing in Coordination with the Health Department for coronavirus in long-term care (LTC) facilities revealed: -After initially performing viral testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and healthcare personnel (HCP) and that transmission has been terminated as described below. -Repeat testing should be coordinated with the local, territorial, or state health department. -Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. -This follow-up viral testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent SARS-CoV-2 transmission. -If viral test capacity is limited, CDC suggests directing repeat rounds of testing to residents who leave and return to the facility (e.g., for outpatient dialysis) or have known exposure to a case (e.g., roommates of cases or those cared for by a HCP with confirmed SARS-CoV-2 infection). -For large facilities with limited viral test capacity, testing only residents on affected units could be considered, especially if facility-wide repeat viral	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 125	D 338		

testing demonstrates no transmission beyond a limited number of units.

Telephone interview on 09/16/20 at 4:10pm with the Chief Operating Officer (COO) revealed:
-Residents with negative test results were monitored for signs and symptoms and would be re-tested if needed.
-Vital signs for residents were taken and recorded each shift.
-She spoke with the local health department (LHD) and followed their guidance.
-She did not receive any guidance on re-testing.

Interview with the facility's Medical Director on 09/18/20 at 12:41pm revealed:
-He was the physician for most of the residents in the building.
-The facility had tested all the residents and staff in the building a few weeks ago.
-There were no residents that were exhibiting signs and/or symptoms of Covid-19 and they were only going to test those who presented with symptoms.
-Based on availability, they would re-test the negative residents and/or staff who presented with symptoms.
-They did not have the man power, or the swabs required to do the weekly re-testing.
-The guidance regarding the re-testing of the negative residents and staff was for nursing homes.
-There were differing opinions regarding what the LHD asked the facility to do.
-He referred them to their local health department.
-Now, they had plans to re-test the negatives the following week (week of 09/21/20).

Interview with the Registered Nurse Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 338	Continued From page 126	D 338		

from the LHD on September 18, 2020 at 10:00am revealed:
-We recommended for the facility to conduct viral testing of all staff and residents once the outbreak began.
-We also recommended to the COO of the facility to conduct weekly testing of all negative residents until no other positive cases were identified for 14 days.
-Retesting would help the facility identify which residents maybe asymptomatic but need to be monitored along with the symptomatic residents and aide in slowing transmission.
-The facility stated they were not going to conduct additional testing after the outbreak but just quarantine their residents.
-Our agency did not have the resources to assist with the ongoing testing but we could have provided information to the facility on testing resources.
-The health department did not have the authority to require the facility to follow our recommendations during the COVID-19 outbreak.

Review of an email received by the COO on 08/24/20 at 12:57pm from the LHD revealed:
-The LHD provided the facility with a link to the NCDHHS website for guidance for long-term care facilities, and a link to the CDC website which included general guidance.
-The LHD attached a spreadsheet that would need to be filled out daily for the symptomatic and/or positive staff and residents and emailed to the LHD.
-The facility was to notify the LHD via email of any changes such as new cases or new symptoms.
-The facililty was to call the LHD directly to report any deaths in the facility.

Review of an email received on 09/16/20 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 338	Continued From page 127 1:15pm from the LHD revealed: -The LHD may not have given specific guidance to them about retesting the negatives, but it was on the links provided to the facility via email on 08/24/20. -The facility sent the LHD a copy of their Case Log of Client and Staff with COVID-19 Symptoms spreadsheet on 09/11/20, but had not reached out to the LHD other than that, and had not given any updates since. -The LHD had called the COO one day last week regarding information that the facility considered themselves to be "covid-free" and that was not the case. -The facility still had an active outbreak in the facility,even if the residents in the facility were considered to be recovered. -The facility provided the LHD with a copy of their line list on Friday, 09/11/20, but had not contacted them or given any updates since. Review of the residents' COVID-19 test results and the facility's COVID-19 spreadsheet dated 08/27/20 revealed there were 25 residents who tested positive. Review of the staffs' COVID-19 test results dated 08/27/20 revealed there were 4 staff who tested positive. Review of the residents' second round of COVID-19 test results dated 09/23/20 revealed there were four residents who tested positive who were initially negative. Review of the staffs' second round of COVID-19 test results dated 09/23/20 revealed there was one staff who tested positive who was initially negative.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 338	Continued From page 128	D 338		

Based on record reviews and interviews it was determined 9 residents were hospitalized with a diagnosis which included COVID-19 and 2 died of COVID-19 as of 09/30/20.

a. Interview on 09/15/20 at 10:47am with the Administrator and Chief Operating Officer (COO) revealed:
-The first case of COVID-19 in the facility was confirmed on 08/21/20.
-Facility-wide testing was ordered and performed on 08/27/20.
-The facility tested 116 residents and 28 staff members.
-There were 4 staff that tested positive for COVID-19.
-Two staff worked while positive to meet staffing requirements.
-The two staff that worked were asymptomatic and were to work only with the COVID-19 positive residents.

Review of COVID-19 test results for a medication aide (MA) revealed the MA's test was collected on 08/28/20 and results were positive for COVID-19 on 08/30/20 at 10:27am.

Review of the staff time sheets revealed the MA who was positive for COVID-19 on 08/30/20 worked the following shifts:
-On 08/30/20 from 12:00am to 1:12pm, and from 8:24pm to 11:48am on 08/31/20.
-On 09/05/20 from 6:59pm-8:20am
-On 09/07/20 from 7:09am to 8:08pm
-On 09/08/20 from 3:12am-4:21pm
-On 09/09/20 from 3:08am to 7:10pm

Review of Resident #15's current FL2 dated 08/05/20 revealed diagnoses included ulcerative colitis, atherosclerosis, chronic obstructive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 129	D 338		

pulmonary disease (COPD), peripheral vascular disease and type II diabetes.

Review of the facility's COVID-19 testing log dated 08/27/20 revealed Resident #15 was negative for COVID-19 on 09/03/20.

Review of Resident #15's record revealed he resided on the 3rd floor on the negative COVID-19 hallway.

Review of Resident #15's August 2020 electronic medication administration record (eMAR) revealed there was documentation of 2 medications administered on 08/30/20 at 12:00pm by the staff who tested positive for COVID-19.

Review of Resident #15's September 2020 eMAR from 09/01/20-09/09/20 revealed there was documentation of 8 medications administered on 09/05/20, and 15 medications administered on 09/08/20 and 09/09/20 by the staff who tested positive for COVID-19.

Review of Resident #15's hospital records revealed:
-He was evaluated in the Emergency Department (ED) on 09/09/20 with chief complaints of shortness of breath, cough, weakness, difficulty walking and increased fatigue.
-He was noted to be severely anemic and hypotensive upon arrival to the ED.
-Blood pressures were in the 70's and he received an epinephrine drip (used to treat septic shock) by EMS on route to the hospital.
-He was tested at the hospital on 09/09/20 and results were positive for COVID-19.
-He was admitted to the hospital on 09/10/20 at 2:18am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 338	Continued From page 130 Telephone interview on 09/22/20 at 1:01pm with the COO revealed: -Resident #15 was admitted for "non-covid" related issues, but the hospital automatically tested him for COVID-19. -The hospital reported to the facility that he was COVID-19 positive on 09/11/20. -He was currently at the hospital. Telephone interview on 09/28/30 at 11:56am with Resident #15's Health Care Power of Attorney (HCPOA) revealed: -Resident #15 was still at the hospital. -He was COVID-19 positive with pneumonia, fevers, weakness and shortness of breath. -He was initally on bilevel positive airway pressure (BIPAP), but was currently on 8 liters per minute oxygen with a nasal cannula. -He also had a nasopharyngeal feeding tube (a tube that carries food and medicine to the stomach through the nose). Review of an email received from one of the facility's owners on 09/28/20 at 1:50pm revealed: -The facility allowed staff to work while they were positive for COVID-19. -They were asymptomatic and were only allowed to work with residents that were also positive. - "This is acceptable per the CDC and the health department knew this and they were ok with it." Telephone interview on 09/28/20 at 4:16pm with the LHD Registered Nurse (RN) revealed: -Only in a "dire emergency" could COVID-19 positive staff work if they had no other choice to meet staffing requirements. -Staff who were COVID-19 positive must be totally asymptomatic in order to work.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 131	D 338		

Interview on 9/21/20 at 2:58pm with the Administrator revealed:
-She was responsible for the staffing schedule.
-They were short staffed due to staff being afraid to work, had quit, or had tested positive for COVID-19.
-She, the Activity Director (AD), and the Infection Control manager (ICM) had filled in on occasion since the outbreak began in August 2020, to provide direct care to residents.

Telephone interview on 09/24/20 at 1:09pm with the Chief Operating Officer (COO) revealed:
-She and the Administrator had reached out to several contract agencies on several occasions.
-They did not have any staff to offer us or staff did not want to work in a COVID-19 positive facility
-On 9/22/20, she had contracted with [name of staffing agency] to start helping out.
-The staffing agency was providing the facility with MAs and PCAs.
-The facility tried to get help with staffing since the outbreak happened at the end of August 2020.
-The Admininistrator was responsible for the staffing schedule.
-"I had instructed her to reach out to the NC Emergency Management office, but I am not aware if she did."

Telephone interview with the MA on 09/28/20 at 3:48pm revealed:
-She normally worked on first shift.
-She was not aware staff were working while they had symptoms or were positive for COVID-19.
-Management was responsible for making decisions regarding staff working while positive for COVID-19.

A second telephone interview with the COVID-19 positive MA on 09/30/20 at 10:47am was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 132	D 338		

unsuccessful.

b. Review of the facility's COVID-19 infection control policy related to screening of staff and essential visitors revealed:
-Ensure screening of all staff and essential visitors by actively checking prior to entry for symptoms of respiratory infection, dry cough, shortness of breath and fever.
-staff and essential visitors with any symptom (including cough only) should not enter the community until three days after symptoms have resolved.

Review of the facility's COVID-19 testing spreadsheet revealed there were 25 residents who had tested positive between 08/21/20 and 09/03/20.

Review of the staffs' COVID-19 test results dated 08/27/20 revealed there were 4 staff who tested positive.

Observation of the facility upon entrance on 09/15/20 at between 8:49am and 9:15am revealed:
-There was one digital infrared forehead no-touch thermometer at the desk for visitors to take their temperature.
-There was a sign-in sheet with space to include name and purpose of visit, there were several questions related to COVID-19 exposure.
-There were instructions for guests to sign in and answer questions.
-There was no staff present to ensure screening was complete or to ensure temperatures were within normal limits or that screening questions were answered appropriately.
-There were no instructions posted for staff or visitors to not enter if they had an abnormal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 338	Continued From page 133	D 338		

temperature.
-There was a PPE station which had gloves, gowns, face masks, face shields, shoe covers, and a large cardboard trash receptacle available for staff and visitors.
-There were two signs posted on the entrance doors related to no face-to-face visitation for residents and staff.
-There was one sign regarding deliveries, and another sign posted regarding limited visitation with residents (through the glass).

Interview with the Infection Control Manager (ICM) on 09/15/20 at 9:25am revealed:
-She was responsible for ensuring all infection control protocols were adhered to by the staff including proper use of PPE, handwashing, hand sanitizing, and proper disposal of PPE.
-Staff was required to wear gloves, masks and face shields during their shift.
-She monitored each floor several times a day to ensure staff were compliant with facility policy for infection control.
-There were no active cases of COVID-19 in the facility, or residents with symptoms (there was a positive COVID-19 resident on the second floor).

Interview on 9/15/20 at 10:00am with the Administrator revealed:
-The facility was considered "COVID recovered" now because they were beyond 10 days since the first positive test result.
-They had been deep cleaning rooms after the 10-day quarantine period had passed.
-The COO was the facility's corporate infection control person
-All residents wore a mask when they left their rooms.

Observation on 09/15/20 at 10:30am to10:40am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 134	D 338		

in the front lobby revealed:
-There was no staff monitoring the screening station.
-At 10:35am a visitor entered the facility and did not know whether to self-screen or wait for someone.
-At 10:40am, the local county Adult Home Specialist (AHS) went to get a staff to assist the visitor.
-The business office manager (BOM) returned with the AHS, screened the visitor and returned to her office.
-The manager's offices on the first floor were not in view of the entrance to the facility and the screening station.
-At 10:45am a medical equipment delivery person came into the facility to deliver medical equipment and there was no one at the screening station.
-He sat down to wait for a passing staff to be alerted to his delivery.
-After 12 minutes, a staff person walked by and signed for the delivery.
-The medical equipment driver stated the facility has requested he wait in the entrance area until someone was available to sign for the delivery.

Interview on 09/15/20 at 10:55am with Activity Director (AD) revealed:
-The transportation staff was responsible for covering the COVID-19 screening desk in the lobby.
-If they were not available, the business office manager (BOM), Infection Control Manager (ICM) or she would cover the screening area at the front desk.

Interview on 09/15/20 at 4:50pm with the Administrator revealed:
-The residents were screened for COVID-19 symptoms every eight hours and the care staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 135	D 338		

were screened at the beginning of each shift.
-Care staff screenings were reviewed by the supervisor in the lobby, during each shift change.
-The AD screened all non-resident care staff and determined if they were safe to work.
-The care staff were not aware of the temperature parameters related to the screening.
-The temperature parameters were the responsibility of the supervisor.

Interview on 09/15/20 at 11:04am with a personal care aide (PCA) revealed:
-Staff come in through the front door screening station, take their own temperatures, answered the screening questions and put on their PPE.
-Staff was required to wear full PPE-gowns, gloves, face masks and face shields while working.

Confidential interviews revealed:
-The staff do not change gowns and gloves between residents' care, "they go room to room without changing."
-A medication aide (MA) was passing medications in the facility that tested positive for COVID-19.
-There were residents that tested positive for COVID-19 "wandering around the building."
-The first time they saw an isolation cart used in the facility was on 09/15/20 outside the door of a newly diagnosed case of COVID-19 positive on the second floor.
-On 09/14/20, a resident who tested positive for COVID-19 was at the front desk using the phone.

Confidential staff interviews revealed:
-The information obtained from the Administrator, currently was there were no active COVID-19 residents.
-All the residents had to stay in their rooms unless they smoked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 136 -Some residents were still showing symptoms including coughing, lethargy, and stomach problems. Interview on 09/16/20 at 10:15am with the Administrator revealed: -The COO was the contact person for COVID-19 issues. -The third floor was the quarantine floor. -On 08/24/20, the facility ordered COVID-19 tests for the community. -On 08/21/20, she and the COO contacted the Local Health Department (LHD) for guidance and had been following their directives. Telephone interview on 09/16/20 at 4:10pm with the COO revealed: -They were notified of the second positive case and tested all residents and staff and isolated the entire facility and had all residents stay in their rooms. -They designated the back hall on the third floor for all positive residents. -Staff cleaned the vacant rooms on the third floor before the COVID-19 positive residents were moved in during their recovery. -Designated staff were assigned to the COVID-19 positive hall. -Residents with negative test results were screened each shift for signs and symptoms of COVID-19 and would be re-tested if needed. -Vital signs for residents were taken and recorded each shift. Interview with a housekeeper on 09/16/20 at 11:55am revealed: -She screened her temperature every day prior to starting her shift. -She was responsible for obtaining her own temperature and documenting the results.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 338	Continued From page 137 -She was responsible for answering the COVID-19 screening questions herself. -A high temperature to her would be 98.6 degrees. Interview with the home health (HH) Physical Therapist (PT) on 09/16/20 at 12:20pm revealed: -She was in the facility daily to see residents. -She was responsible for COVID-19 self-screening and obtaining her own temperature. -She did not use the thermometer the facility provided but took her own temperature in the car and wrote down the results. Telephone interview with the local Health Department Infection Disease Registered Nurse on 09/17/20 at 1:10pm revealed: -The county did not give guidelines for screening. -The facility was responsible for obtaining temperatures and asking COVID-19 questions. -It was best if one person was assigned to the COVID-19 screening process. -It was not recommend the facility staff screen themselves for COVID-19. 3. Observation on 09/15/20 between 09:00 and 9:15am on the facility's smoking area revealed: -There were 7 residents sitting in the smoking area. -The residents were sitting approximately 2 feet apart. -The 7 residents were not wearing face masks when they were not smoking. -Another resident got off the elevator without wearing a face mask, he came into the smoking area. Observation of the sign on the smoking area door leading to the smoking area revealed, "Maintain social distance of 6 feet at all times."	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 338	Continued From page 138 Interview with one of the smoking resident on 09/15/20 at 9:15 revealed: -She resided on the third floor. -She was tested for COVID-19 once but did not know the results. -Staff did not tell us if we were negative or positive. -She knew residents on the third floor were positive. -Residents did not always wear a face mask in the smoking area. Interviews with 3 residents in the smoking area on 09/15/20 at 9:10am revealed: -Two weeks ago, the residents were tested for COVID-19, but they did not know the results. -"I was never told why I was moved to the third floor." -"I was not tested for COVID-19." -"I just come downstairs when I want to." -"I was never told not to sit beside each other in the smoking area." Interview with a medication aide (MA) on 09/15/20 at 9:45am revealed: -The facility moved all the COVID-19 positive residents to the third floor. -The residents who tested positive were notallowed to go out to the smoking area. -All residents were to wear face masks when they go out of their rooms. -There should be only be 5 residents in the smoking area at one time. -They should be practicing social distancing. Interview with the Administrator on 09/21/20 at 2:25pm revealed: -Residents were given a scheduled time for their smoke breaks.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 338	Continued From page 139 -Residents were to wear a face mask when they leave the rooms or if they were in the hall. -Signs were posted in the smoke area for social distancing and how many residents are allowed in the smoking area at one time. -There were no staff assigned to the smoking area to monitor the social distancing or the number of residents allowed in the smoking area. 4. Observation of the Administrator on 09/15/20 around 9:20am revealed she was not wearing gloves, a gown or a faceshield on the designated COVID-19 third floor. Observation on 09/15/20 at 12:55pm of staff in the breakroom revealed: -They were seated side-by-side at the breakroom table. -There were four chairs and one table approximately 6 feet long. -Staff were not social distancing six feet apart as they were eating lunch.. -There was a large plastic container of cookies that was being shared by all staff. Observation on 09/18/20 at 9:45am of the breakroom revealed: -There were still four chairs and one table approximately 6 feet long in the room. -There was a large plastic container of cookies and two boxes of doughnuts on top of the microwave that was available to the staff. Observation on 09/22/20 around 8:15pm of the Administrator revealed she was not wearing gloves, a gown or a faceshield on the first floor. _____ The facility failed to ensure recommendations and guidance established by the Centers for	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 140 Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to practicing infection control procedures to reduce the risk of transmission and infection, during administration of medications, COVID-19 positive staff working with COVID-19 negative residents, not actively screening staff and essential visitors, residents not practicing social distancing while in the smoking area, and staff not wearing appropriate PPE and not practicing social distancing requirements. The facility's failure resulted in serious risk for physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 15, 2020 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 30, 2020.	D 338		
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	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 358	Continued From page 141	D 358		

and procedures.

This Rule is not met as evidenced by:
A2 VIOLATION

Based on record reviews and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 4 of 9 sampled residents (Resident #2, #10, #3, and #4) related to not administering a diuretic and a scheduled pain medication, and not having available for administration medications for allergies, acid reflux, and a hand held inhaler for shortness of breath (Resident #2); not administering a blood pressure medication, a medication for nerve pain and a phosphate binder three times a week while at dialysis treatment (Resident #10); not having a nebulizer medication available for use for shortness of breath (Resident #3) and not administering a blood pressure medication (Resident #4).

The findings are:

Review of the facility's medication administration policy revealed medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders.

1. Review of Resident #2's current FL2 dated 05/01/20 revealed diagnoses included atrial fibrillation, cardiomyopathy, hypothyroidism and depression.

a. Review of Resident #2's signed provider's order dated 07/08/20 revealed there was an order for Furosemide 20mg one tablet daily, a medication used to treat fluid buildup due to heart failure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 358	Continued From page 142 Review of Resident #2's July, August and September 2020 electronic Medication Administration Records (eMARs), from 07/09/20 through 09/15/20 revealed: -There was no entry for Furosemide 20mg one tablet daily. -Resident #10 missed 62 of 62 possible doses of Furosemide 20mg tablets daily. Telephone interview with a pharmacist at the facility's contracted pharmacy that provides medications for Resident #2 on 09/25/20 at 4:10pm revealed: -The pharmacist had a record of an electronic prescription (e-script) sent on 07/08/20 for Furosemide 20mg one tablet daily. -On 07/08/20 a blister pack of 30 tablets of Furosemide 20mg one tablet daily were sent to the facility. -On 07/31/20 a blister pack of 30 tablets of Furosemide 20mg one tablet daily were sent to the facility. -On 08/23/20 a blister pack of 30 tablets of Furosemide 20mg take 1 tablet daily were sent to the facility. -This pharmacy did not have access to the facility's eMAR and did not enter orders onto the eMAR. b. Review of Resident #2's signed provider's order dated 05/01/20 revealed there was an order to administer Furosemide 20mg if Resident #2's daily weight was 3 pounds greater overnight or 5 pounds greater in a week. Review of Resident #2's July 2020 electronic Medication Administration Records (eMARs) revealed: -There was an entry for Furosemide 20mg if daily	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 143	D 358		

weight was 3 pounds greater overnight or 5 pounds greater in a week.
-Resident #2's weight was documented on 07/04/20 as 134 pounds.
-Resident #2's weight was documented on 07/05/20 as 165 pounds.
-There was no documentation Furosemide 20mg was administered.
-Resident #2's weight was documented on 07/11/20 as 133 pounds.
-Resident #2's weight was documented on 07/12/20 as 163 pounds.
-There was no documentation Furosemide 20mg was administered.
-Resident #2's weight was documented on 07/17/20 as 132 pounds.
-Resident #2's weight was documented on 07/18/20 as 163 pounds.
-There was no documentation Furosemide 20mg was administered.
-Resident #2's weight was documented on 07/26/20 as 120 pounds.
-Resident #2's weight was documented on 07/27/20 as 133 pounds.
-There was no documentation Furosemide 20mg was administered.

Review of Resident #'s August 2020 eMAR revealed:
-There was an entry for Furosemide 20mg if daily weight was 3 pounds greater overnight or 5 pounds greater in a week.
-Resident #2's weight was documented on 08/01/20 as 133 pounds.
-Resident #2's weight was documented on 08/02/20 as 162 pounds.
-There was no documentation Furosemide 20mg was administered.
-Resident #2's weight was documented on 08/10/20 as 130 pounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 144 -Resident #2's weight was documented on 08/11/20 as 134 pounds. -There was no documentation Furosemide 20mg was administered. -Resident #2's weight was documented on 08/15/20 as 134 pounds. -Resident #2's weight was documented on 08/16/20 as 148 pounds. -There was no documentation Furosemide 20mg was administered. -Resident #2's weight was documented on 08/23/20 as 123 pounds. -Resident #2's weight was documented on 08/24/20 as 133 pounds. -There was no documentation Furosemide 20mg was administered. -Resident #2's weight was documented on 08/29/20 as 120 pounds. -Resident #2's weight was documented on 08/30/20 as 130 pounds. -There was no documentation Furosemide 20mg was administered. Review of Resident #2's September 2020 eMAR, from 09/01/20 through 09/15/20, revealed: -There was an entry for Furosemide 20mg if daily weight was 3 pounds greater overnight or 5 pounds greater in a week. -Resident #2's weight was documented on 08/30/20 as 130 pounds. -Resident #2's weight was documented on 09/06/20 as 160 pounds. -There was no documentation Furosemide 20mg was administered. Observation of Resident #2's medications on hand on 09/18/20 at 2:45pm revealed: -There was a blister pack of Furosemide tablets 20mg, with a pharmacy generated label ' one tablet by mouth every day', filled on 07/31/20.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 145 -There were 29 tablets remaining in the blister pack. Observation of Resident #2 on 09/15/20 at 12:10pm revealed: -Resident #2 ambulated with a rollator to the bathroom with the assistance of staff. -Resident #2 had to stop several times stating she was tired and was short of breath. -Resident #2 ambulated back to her chair with frequent stops due to fatigue and shortness of breath. -Sitting in her chair, bilateral feet were observed to be puffy and slightly edematous. Interview with the Medication Aide (MA)/Floor Supervisor on 09/22/20 at 9:15pm revealed: -When a new order was sent to the facility for a resident, the MA or MA/Floor Supervisor faxed the order to the pharmacy. -She reviewed all new orders. -She compared the order with the entry on the eMAR to ensure it was transcribed correctly. -If the orders on the eMAR were correctly transcribed, she approved the order on the eMAR. -If the order was sent by e-script, she would not be aware of that order. -The pharmacy Resident #2 received her medications from was not the pharmacy that entered the physician's orders on the eMAR. -The MAs and MA/Floor Supervisors did frequent cart audits and compared the medications with the eMARS. -The pharmacy also completed monthly cart audits. -The MA/Floor Supervisors would contact the provider if an order needed clarification. -She did not know why the MA/Floor Supervisor for Resident #2's floor was not informed by the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 146	D 358		

MA the pharmacy generated label on the Furosemide blister pack did not correspond to the eMAR.
-She did not know who performed the cart audits on the medication cart within the last 2 months.

Interview with the MA on 09/18/20 at 10:45am revealed:
-She administered Resident #2's medications.
-She administered medications as entered on the eMAR.
-There had been a PRN (as needed) handwritten notation at the top of the Furosemide blister pack.
-She thought the pharmacy generated label was an error.

Interview with a second MA/Floor Supervisor on 09/21/20 at 10:30am revealed:
-The MA/Floor Supervisor assigned to the resident's floor would be responsible to review the eMARS and order medications for those residents.
-She did not know who was assigned to that floor now.

Interview with another MA/Floor Supervisor on 09/21/20 at 8:45am revealed:
-Medication cart audits were conducted monthly by the MA/Floor Supervisors and were documented and placed in a binder.
-The MA/Floor Supervisor used the eMARS as a reference during a medication cart audit.
-The MA/ Floor Supervisor on the first floor of the facility reviewed the medication cart audit binder.
-The MA/Floor Supervisors ordered medications when needed in between the monthly delivery.
-The MA/Floor Supervisors contacted the facility contracted pharmacies with any change of medication orders.
-If the MAs were aware of a discrepancy between

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 147	D 358		

the pharmacy generated label on the blister pack of medication and the order entry on the eMAR, they should notify the MA/Floor Supervisor.
-She was never notified the pharmacy generated label on the blister pack of Furosemide was not consistent with the order entry on the eMAR.
-She had not conducted a medication audit on the third-floor medication carts.
-She thought the pharmacy Registered Nurse (RN) had conducted a medication cart audit a few weeks ago.

Telephone interview with Resident #2 on 09/24/20 at 11:44am revealed:
-She used to weigh herself every day.
-She kept a scale under her bed and used it independently to determine her weight.
-She documented the weight on the calendar in her room and the staff could look at it.
-She did not know if the staff looked at the weight entry or not, but it was available for them to review.
-She did not know the information regarding her daily weight, reviewed by the MA, was used to determine whether a PRN Furosemide tablet should be administered as ordered by the physician.
-She knew if she weighed 3 pounds or more, she should report it to the staff.
-She did not remember what happened, if anything, if she did weigh greater than 3 pounds in a day.
-She did not remember receiving an additional medication tablet for increased weight gain.
-She did not remember when the last time she weighed herself, "It's been a long time."

Telephone interview with the primary care provider (PCP) on 09/18/20 at 1:45pm revealed:
-She had been Resident #2's provider since July

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 148	D 358		

2020.
-Since she could not review the resident's record, she relied on the entries in the eMARS.
-She knew Resident #2 had an entry on the eMAR to administer Furosemide 20mg as needed (PRN) with a weight gain of 2-3 pounds in one day.
-She did not know the weights were documented above the parameters (2-3 pounds in a day) and Resident #2 was not administered PRN Furosemide 20mg.
-She did not know Resident #2 had a scheduled order for Furosemide 20mg prescribed on 07/08/20.
-Resident #2 had a diagnosis of atrial fibrillation and could be hospitalized with heart failure due to fluid overload, if she did not receive the furosemide as prescribed.

c. Review of Resident #2's provider's order dated 05/14/20 revealed there was an order for Hydrocodone-Acetaminophen 7.5/325mg, a narcotic medication used to treat pain, to be scheduled every 6 hours, and the as needed order (PRN) to be discontinued.

Review of Resident #2's July 2020 electronic Medication Administration Records (eMARs) revealed:
-There was an entry for Hydrocodone-Acetaminophen 7.5/325mg every 6 hours PRN pain.
-There was documentation Resident #2 received 52 doses of Hydrocodone-Acetaminophen from 07/01/20 through 07/31/20.
-There was no entry for Hydrocodone-Acetaminophen 7.5/325mg to be scheduled every 6 hours.
-Resident #2 should have received 124 scheduled doses of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 149 Hydrocodone-Acetaminophen from 07/01/20 through 07/31/20. Review of Resident #2's August 2020 eMAR revealed: -There was an entry for Hydrocodone-Acetaminophen 7.5/325mg every 6 hours PRN pain. -There was documentation Resident #2 received 50 doses of Hydrocodone-Acetaminophen from 08/01/20 through 08/31/20. -There was no entry for Hydrocodone-Acetaminophen 7.5/325mg to be scheduled every 6 hours. -Resident #2 should have received 124 scheduled doses of Hydrocodone-Acetaminophen from 08/01/20 through 08/31/20. Review of Resident #2's September 2020 eMAR revealed: -There was an entry for Hydrocodone-Acetaminophen 7.5/325mg every 6 hours PRN for pain. -There was documentation Resident #2 received 26 doses of Hydrocodone-Acetaminophen from 09/01/20 through 09/21/20. -There was no entry for Hydrocodone-Acetaminophen 7.5/325mg to be scheduled every 6 hours. -Resident #2 should have received 84 doses of Hydrocodone-Acetaminophen from 09/01/20 through 09/21/20. Telephone interview with the pharmacist at the facility contracted pharmacy on 09/25/20 at 4:10pm revealed: -The dispense history for Hydrocodone-Acetaminophen 7.5/325mg every 6 hours as needed was as follows:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 150 -On 05/13/20 a blister pack of 30 tablets of Hydrocodone-Acetaminophen 7.5/325mg every 6 hours as needed (PRN) was delivered to the facility. -On 05/21/20 the prescription was changed to Hydrocodone-Acetaminophen 7.5/325mg every 6 hours scheduled, and a blister pack of 120 tablets was dispensed and delivered to the facility. -There was no additional signed prescription by the provider, as required by law, for the next month's scheduled dosage of Hydrocodone-acetaminophen. -The pharmacy could not discontinue the order without a signed discontinue order from the prescribing provider. -The Hydrocodone-Acetaminophen 7.5/325mg defaulted back to a PRN order. -On 06/24/20 a blister pack of 30 tablets of Hydrocodone-Acetaminophen 7.5/325mg every 6 hours PRN was dispensed and delivered to the facility. -On 09/02/20 a blister pack of 30 tablets of Hydrocodone-Acetaminophen 7.5/325mg every 6 hours PRN was dispensed and delivered to the facility. Observation of Resident #2's medications on hand on 09/18/20 at 2:45pm revealed: -There was a blister pack of Hydrocodone-Acetaminophen 7.5/325mg, with a pharmacy generated label "take one tablet as needed every 6 hours", filled on 09/02/20. -There were 19 tablets remaining in the blister pack. Telephone interview with the primary care provider (PCP) on 09/18/20 at 1:45pm revealed: -The previous provider scheduled the Hydrocodone-Acetaminophen 7.5/325mg every 6 hours for appropriate pain management.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 151	D 358		

-Her expectation was that the facility staff would administer medications as ordered by the provider.
-If there was a clarification needed with a medication order, the staff should contact her as the PCP.

d. Review of Resident #2's provider's order dated 05/14/20 revealed there was an order for Banophen 25mg, used to treat the symptoms of an allergic reaction, every 4 hours as needed.

Review of Resident #2's electronic administration records (eMARS) from July 2020-September 2020, revealed there was an entry for Banophen 25mg take one capsule every 4 hours as needed.

Observation of Resident 2's medications on hand on 09/18/20 at 2:45pm revealed Banophen, was not available for administration.

e. Review of Resident #2's provider's order dated 05/14/20 revealed there was an order for Famotidine 20mg, used to treat gastroesophageal reflux disease (GERD), take one tablet at bedtime as needed for reflux.

Review of Resident #2's electronic administration records (eMARS) from July 2020-September 2020, revealed there was an entry for Famotidine 20mg take one tablet at bedtime as needed for reflux.

Observation of Resident 2's medications on hand on 09/18/20 at 2:45pm revealed Famotidine 20mg daily as needed for reflux was not available for administration.

f. Review of Resident #2's physician's order dated 05/14/20 revealed there was an order for Ventolin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 152	D 358		

HFA 108mcg, used to increase air flow to the lungs, inhale 2 puffs every 4 hours as needed for shortness of breath.

Review of Resident #2's electronic administration records (eMARS) from July 2020-September 2020, revealed there was an entry for Ventolin HFA 108mcg inhale 2 puffs every 4 hours as needed for shortness of breath.

Observation of Resident 2's medications on hand on 09/18/20 at 2:45pm revealed Ventolin HFA 108mcg inhale 2 puffs every 4 hours as needed for shortness of breath was not available for administration.

Interview with a medication aide (MA) on 09/21/20 at 8:45am revealed:
-She did not know why Resident #2's PRN medications were not available for administration.
-She did not conduct medication cart audits.
-If a resident did not request a PRN medication, she may not be aware it was missing from the medication cart.

Interview with a second MA/Floor Supervisor on 09/21/20 at 10:30am revealed:
-The MA/Floor Supervisor assigned to the resident's floor would be responsible to review the eMARS and order medications for those residents.
-She did not know why the MA/Floor Supervisor for that floor had not ordered Resident #2's PRN medications.
-She did not know who was assigned to that floor now as the MA/Floor Supervisor.

Telephone interview with the LHPS Registered Nurse (RN)on 09/23/20 at 2:43pm revealed:
-She conducted monthly medication cart audits

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 153	D 358		

on six medication carts at the facility.
-She was responsible for removing any expired medications and returning them to the pharmacy.
-She did not review any narcotics.
-She did not ensure the medication labels on the blister packs were consistent with the medication orders entered on the eMAR.
-Her only task in auditing the medication carts was to remove expired medications.

Telephone interview with the primary care provider (PCP) on 09/18/20 at 1:45pm revealed:
-She was not aware Resident #2's prescribed medications were not all available for administration.
-The Home Health nursing has documented Resident #2 was short of breath upon exertion and should have Ventolin HFA available for administration when needed.
-All medications prescribed by the provider for Resident #2 should be available for administration.

Interview with the Administrator on 09/21/20 at 1:15pm revealed:
-It was the responsibility of the MA to inform the MA/Floor Supervisor prescribed medications for a resident were not available for administration.
-It was the responsibility of the MA/Floor Supervisor to ensure medications were available for the residents on her floor.
-It was the responsibility of the MA/Supervisor to contact the pharmacy and request medications that were not delivered in the monthly batch of medications.

2. Review of Resident #10's current FL2 dated 12/24/19 revealed diagnoses included end stage renal disease (ESRD), primary hypertension, hypothyroidism, and gastroesophageal reflux

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 154 disease (GERD). a. Review of Resident #10's signed provider's order dated 03/26/20 revealed an order for Renvela 800mg, a medication used to control phosphorous levels in persons who were on dialysis, one tablet four times a day with meals or snacks. Review of Resident #10's July 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Renvela 800mg one tablet four times a day with meals or snacks, to be administered at 7:00am, 12:00pm, 5:00pm and 7:00pm. -There was documentation Resident #10 was not administered Renvela 800mg at 12:00pm on 07/01/20, 07/03/20, 07/06/20, 07/08/20, 07/10/20, 07/13/20, 07/15/20, 07/17/20, 07/20/20, 07/22/20, 07/24/20, 07/27/20 and 07/31/20. -There was documentation Resident #10 was LOA-a leave of absence from the facility-on 07/01/20, 07/15/20, 07/22/20, 07/24/20, and 07/31/20. -On the remaining Monday, Wednesday and Friday days from 07/01/20 through 07/31/20, the documented reason for missing the 12:00pm dosage of Renvela, while the resident was at dialysis treatment, was "patient refused." Review of Resident #10's August 2020 eMAR, from 08/01/20 through 08/14/20, revealed: -There was an entry for Renvela 800mg one tablet four times a day with meals or snacks, to be administered at 7:00am, 12:00pm, 5:00pm and 7:00pm. -There was documentation Resident #10 was not administered Renvela 800mg at 12:00pm on 08/03/20, 08/05/20, 08/07/20, 08/10/20, 08/12/20	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 155	D 358		

and 08/13/20.
-There was documentation Resident #10 was LOA-a leave of absence from the facility-on 08/03/20, and 08/12/20.
-On the remaining Monday, Wednesday and Friday days, from 08/01/20 through 08/14/20, the documented reason for missing the 12:00pm dosage of Renvela, while the resident was at dialysis treatment, was "patient refused."
-Renvala 800mg was discontinued on 08/14/20.

Telephone Interview with the Registered Nurse (RN) at the dialysis center on 09/18/20 at 10:22am revealed any medication Resident #10 missed, due to his dialysis treatments, should be administered when he returned to the facility.

Interview with the Medication Aide (MA) on 09/15/20 at 12:00pm revealed:
-Resident #10 attended dialysis treatment 3 times a week.
-If he was at dialysis, he could not be administered the medications at noon time.
-If a resident was on LOA, they did not receive their medications during that time.
-LOA was documented as the reason Resident #10's medications were not administered on dialysis treatment days.
-She did not report the missed medications to the provider because, "she (the provider) knew he was at dialysis."

Interview with the MA/Floor Supervisor on 09/25/20 at 1:24pm revealed:
-When Resident #10 was at dialysis treatment, the MA sent his noontime medications with him.
-The MAs did not document in the progress notes that Resident #10 had been given his medications to administer when he was LOA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 156	D 358		

Telephone interview with Resident #10's primary care provider (PCP) on 09/18/20 at 1:45pm revealed:
-Renvela was a phosphate binder and was used to control phosphorous levels in people with chronic kidney disease who were on dialysis.
-Resident #10 should absolutely be taking Renvela as prescribed. Elevated phosphorous levels could cause problems with muscles including the heart.
-The facility should be coordinating with the dialysis staff to schedule Renvela when Resident #10 returned from dialysis.
-She did not know Resident #10's noontime dose of Renvela 800mg was not administered on the 3 days a week he was at dialysis treatment.

b. Review of Resident #10's signed provider's order dated 12/24/19 revealed:
-There was an order for Hydralazine 100mg, used to treat high blood pressure, take one tablet three times a day.
-On dialysis treatment days, hold Hydrazaline if the systolic blood pressure was less than 130 or the diastolic blood pressure was less than 80.

Review of Resident #10's July 2020 electronic Medication Administration Record (eMAR), from 07/09/20 through 07/31/20, revealed:
-There was an entry for Hydralazine 100mg one tablet three times a day, to be administered at 7:00am, 12:00pm and 7:00pm.
-There was documentation Resident #10 was not administered Hydralazine 100mg at 12:00pm on 07/10/20, 07/13/20 07/15/20, 07/17/20, 07/20/20, 07/22/20, 07/24/20, 07/27/20 and 07/31/20.
-There was documentation Resident #10 was LOA-a leave of absence from the facility-on 07/15/20, 07/22/20, 07/24/20 and 07/31/20.
-There was documentation on the remaining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 157 Monday, Wednesday and Friday treatment days, 07/10/20 through 07/27/20, the reason for missing the 12:00pm dose of medication while the resident was at dialysis was "patient refused". -Resident #10's blood pressure readings from 07/01/20 through 07/31/20 ranged from 143/67-185/80 on the days the 12:00pm dose of Hydralazine was not administered. Review of Resident #10's August 2020 eMARs revealed: -There was an entry for Hydralazine 100mg 1 tablet three times a day, to be administered at 7:00am, 12:00pm and 7:00pm. -There was documentation Resident #10 was not administered Hydralazine 100mg at 12:00pm on 08/03/20, 08/05/20, 08/07/20, 08/10/20, 08/12/20, 08/17/29, 08/19/20, 08/21/20, 08/26/20, 08/28/20 and 08/31/20. -There was documentation Resident #10 was LOA-a leave of absence from the facility-on 08/03/20, 08/12/20, 08/21/20 and 08/28/20. -There was documentation on the remaining Monday, Wednesday and Friday days, the reason for missing the 12:00pm dosage of medication while the resident was at dialysis was "patient refused." -Resident #10's blood pressure readings from 08/01/20 through 08/31/20 ranged from 137/77-179/72 on the days the 12:00pm dose of Hydralazine was not administered. Review of Resident #10's September 2020 eMAR, from 09/01/20 through 09/23/20, revealed: -There was an entry for Hydralazine 100mg 1 tablet three times a day, to be administered at 7:00am, 4:00pm and 7:00pm. -There was documentation Resident #10 was not administered Hydralazine 100mg at 12:00pm on 09/03/20, 09/08/20, 09/10/20, 09/12/20 and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 158	D 358		

09/15/20.
-There was documentation Resident #10 was LOA-a leave of absence from the facility-on 09/12/20.
-There was documentation on the remaining Monday, Wednesday and Friday days, from 09/03/20 through 09/15/20, the reason for missing the 12:00pm dose of medication while the resident was at dialysis was "patient refused."
-Resident #10's blood pressure readings ranged from 156/66-181/83 on the days the 12:00pm dose of Hydralazine was not administered.

Telephone interview with Resident #10's primary care provider (PCP) on 09/18/20 at 1:45pm revealed:
-Resident #10 was hypertensive and Hydralazine helped to lower his blood pressure.
-She was not aware Resident #10 was not receiving the 12:00pm dose of Hydralazine on dialysis treatment days.
-The facility should work with the dialysis nurse to determine the best times to administer the Hydralazine on treatment days.

c. Review of Resident #10's signed provider's order dated 12/24/19 revealed an order for Gabapentin 100mg, a medication used to treat neuropathic pain, to be administered three times a day.

Review of Resident #10's July 2020 electronic Medication Administration Record (eMAR), from 07/09/20 through 07/31/20, revealed:
-There was an entry for Gabapentin 100mg three times a day, to be administered at 7:00am, 12:00pm and 7:00pm.
-There was documentation Gabapentin 100mg was not administered at 12:00pm on 07/10/20, 07/13/20, 07/15/20, 07/17/20, 07/20/20, 07/22/20,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 159	D 358		

07/24/20, 07/27/20 and 07/31/20.
-There was documentation Resident #10 was LOA-a leave of absence from the facility-on 07/15/20, 07/22/20, 07/24/20 and 07/31/20.
-There was documentation on the remaining Monday, Wednesday and Friday days, from 07/10/20 through 07/27/20, the reason for missing the 12:00pm dose of medication while the resident was at dialysis was "patient refused."

Review of Resident #10's August 2020 eMAR revealed:
-There was an entry for Gabapentin 100mg three times a day, to be administered at 7:00am, 12:00pm and 7:00pm.
-There was documentation Gabapentin 100mg was not administered at 12:00pm on 08/03/20, 08/05/20, 08/07/20, 08/10/20, 08/12/20, 08/17/20, 08/19/20, 08/21/20, 08/26/20, 08/28/20 and 08/31/20.
-There was documentation Resident #10 was LOA-a leave of absence from the facility- on 08/03/20, 08/12/20, 08/21/20 and 08/28/20.
-There was documentation on the remaining Monday, Wednesday and Friday days, from 08/05/20 through 08/31/20, the reason for missing the 12:00pm dose of medication while the resident was at dialysis was "patient refused."

Review of Resident #10's September 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Gabapentin 100mg three times a day, to be administered at 7:00am, 12:00pm and 7:00pm.
-There was documentation Gabapentin 100mg was not administered at 12:00pm on 09/03/20, 09/08/20, 09/10/20, 09/12/20, and 09/15/20.
-There was documentation Resident #10 was LOA-a leave of absence from the facility-on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 160	D 358		

09/12/20.
-There was documentation on the remaining Tuesday, Thursday and Saturday days, from 09/03/20 through 09/15/20, the reason for missing the 12:00pm dose of medication while the resident was at dialysis was "patient refused."

Telephone interview with Resident #10's primary care provider (PCP) on 09/18/20 at 1:45pm revealed:
-She expected Resident #10's prescribed medications to be administered as ordered.
-She was not aware Resident #10 was not receiving the 12:00pm dose of Gabapentin on dialysis treatment days.
-The staff should coordinate with her, or the dialysis clinical team, to arrange alternate times for the 12:00pm medications when he was at scheduled treatments.

Interview with the Administrator on 09/21/20 at 1:15pm revealed:
-The eMAR documentation "LOA" was used when a resident was out of the facility at the time his medication was scheduled.
-Resident #10 had dialysis treatments 3 times a week at the dialysis clinic.
-The MA/Floor Supervisor should have contacted the provider to determine another time the 12:00pm medications could be administered to Resident #10 on the days he was in treatment.
-She did not know if the MA/Supervisor had contacted the provider.
-The MAs could also follow facility policy, sign out the medications to the resident and document the resident was competent to administer the medications while LOA.

Attempted interview with Resident #10 on 09/16/20 at 3:15pm and 09/21/20 at 11:00am was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 161	D 358		

unsuccessful.

3. Review of Resident #3's current FL2 dated 12/30/19 revealed:
-Diagnoses included allergic rhinitis, gastroesophageal reflux disease, and obesity.
-There was an order for Ipratropium/Albuterol solution, one vial every 6 hours as needed for wheezing (a medication placed in a machine and changed into a vapor that is inhaled and opens the airways to the lungs to ease difficulty breathing and increase oxygenation).

Review of Resident #3's signed physician's orders dated 03/26/20 revealed there was an order for Ipratropium/Albuterol nebulizer solution, one vial every 6 hours as needed for wheezing.

Review of Resident #3's "care note" documented on 08/06/20 revealed Resident #3 was being sent out per the on-call provider with chest pain, trouble breathing, and legs hurting.

Review of Resident #3's Emergency Department (ED) documents dated 08/07/20 revealed:
-Resident #3's chief complaint was body aches, sore throat, chest pain, shortness of breath and cough.
-The discharge diagnosis included viral syndrome, sinusitis, viral pharyngitis.
-There was an order to continue Ipratropium-Albuterol (Duo-Neb 0.5mg-2.5mg/3mL inhalation solution) 3mL nebulization every 6 hours as needed for shortness of breath or wheezing.

Review of the Licensed Health Professional Support (LHPS) review completed for Resident #3 on 08/16/20 revealed:
-Inhalation medication by machine was checked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 162	D 358		

as task.
-Resident #3 was ordered "Duo-Nebs every 6 hours as needed with no documented use in the last 30 days".
-The LHPS nurse observed there was no nebulizer machine in the resident room.

Observation of Resident #3's room on 09/21/20 at 3:00pm revealed there was not nebulizer machine available.

Review of Resident #3's July 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Ipratropium/Albuterol nebulizer solution inhale one vial every 6 hours as needed.
-There were no documented administrations from 07/01/20 to 07/31/20.

Review of Resident #3's August 2020 eMAR revealed:
-There was an entry for Ipratropium/Albuterol nebulizer solution inhale one vial every 6 hours as needed.
-There were no documented administrations from 08/01/20 to 08/31/20.

Review of Resident #3's September 2020 eMAR revealed:
-There was an entry for Ipratropium/Albuterol nebulizer solution inhale one vial every 6 hours as needed.
-There were no documented administrations from 09/01/20 to 09/15/20.

Observation of medications on hand on 09/18/20 at 9:45am revealed Ipratropium/Albuterol was not available for administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 163 Telephone interview with the pharmacist at the contracted pharmacy on 09/23/20 at 11:41am revealed: -The pharmacy had an order dated 08/17/16 for Ipratropium/Albuterol 0.5mg-2.5mg/3mL inhalation solution 3mL nebulization every 6 hours as needed for wheezing. -The pharmacy received the signed physician's orders on 03/26/20 that continued the Ipratropium/Albuterol. -The medication was active in their system, however the facility needed to call or fax if they needed the medication filled. -The pharmacy had never filled Ipratropium/Albuterol for Resident #3. Interview with Resident #3 on 09/21/20 at 3:00pm revealed: -There were times he got short of breath and he just sat down to catch his breath. -He did not have any medication to assist with breathing. -He did not have a nebulizer to administer medication to help with shortness of breath, "I'm supposed to". -He could not remember asking staff for the medication when he was short of breath. Interview with a medication aide (MA) on 09/21/20 at 3:05pm revealed: -She had not seen a nebulizer in Resident #3's room. -Resident #3 exhibited shortness of breath at times, however she did not know the resident had an order for Ipratropium/Albuterol. -She never noticed on the eMAR the Ipratropium/Albuterol was available to administer when the resident presented with shortness of breath. -She had never seen a nebulizer in Resident #3's	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 164	D 358		

room.
-The MA/Floor Supervisors were responsible for ordering the nebulizers for the resident.
-If she needed to order medications, she could click refill in the eMAR system.

Interview with another MA on 09/22/20 at 8:41pm revealed:
-Resident #3 presented with shortness of breath when moving around and when he talked too fast.
-Resident #3 never asked for a medication for shortness of breath.
- "Residents know their medications and usually asked for what they needed".
-He never saw a nebulizer in Resident #3's room.
-He never thought to mention the resident needed a nebulizer because he did not know the nebulizer would have helped Resident #3's shortness of breath.

Interview with MA/floor supervisor on 09/22/20 at 8:56pm revealed:
-She had not administered Ipratropium/Albuterol for Resident #3.
-She did not realize the resident had an order for the medication.
-She did not realize Resident #3 did not have a nebulizer.
- "If he has one, it is probably put up somewhere"
-She thought Resident #3 knew what medications he had available and he would ask for what he needs.

Based on interviews and observations it was determined there was no nebulizer machine available in the facility for Resident #3.

Telephone interview with Resident #3's primary care provider (PCP) on 09/22/20 at 8:29am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 165 -She continued the order for Ipratropium/Albuterol when needed after becoming the PCP in July 2020. -She expected Resident #3 to be administered Ipratropium/Albuterol when he displayed shortness of breath or wheezing. -She did not know Resident #3 did not have nebulizer to administer the medication. -No one from the facility reached out to her to obtain an order for a nebulizer. -There would be no way to administer the Ipratropium/Albuterol without having a nebulizer. Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 09/30/20 at 9:36am revealed: -She completed LHPS assessment of residents on a quarterly basis. -She completed the LHPS for Resident #3 in August 2020. -She documented her findings and would hand the forms to any staff person available. -She documented Resident #3 did not have a nebulizer machine, however did not discuss the findings with anyone in the facility. -She thought the staff were responsible for reviewing her assessments and making adjustments accordingly. -She mailed the assessments to the Administrator in August 2020 due to the COVID-19 pandemic. Interview with the temporary Administrator and the Chief Operating Officer (COO) on 09/29/20 at 1:15pm revealed: -Medications were supposed to be administered as ordered. -She expected the MAs to notify the pharmacy if a medication was needed. -She expected the MAs/Floor Supervisor to get an order from the physician for a nebulizer.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 166 -She did not know Resident #3 did not have a nebulizer to administer Ipratropium/Albuterol. -She expected the MAs to look on the eMAR to determine medications available when needed. 4. Review of Resident #4's current FL2 dated 02/20/20 revealed: -Diagnoses included multiple fracture of ribs, muscle weakness, and hypertension. -There was an order for Verapamil 180mg (a medication used to treat high blood pressure) one tablet every morning, hold for blood pressure less than 100, call physician if the systolic blood pressure is greater than 160 or diastolic pressure is greater than 90. Review of Resident #4's signed provider's orders dated 03/26/20 revealed there was an order for Verapamil 180mg every morning, hold for blood pressure less than 100, call provider if the systolic blood pressure is greater than 160 or the diastolic blood pressure is greater than 90. Review of Resident #4's July 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Verapamil 180mg one tablet every morning, hold for blood pressure less than 100, call physician if the systolic blood pressure is greater than 160 or diastolic pressure is greater than 90 at 7:00am. -Verapamil 180mg was documented as administered daily from 07/01/20-07/31/20. -There were no blood pressures documented, and it could not be determined if the resident was within parameters to receive the medication. Review of Resident #4's August 2020 eMAR revealed: -There was an entry for Verapamil 180mg one	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 167	D 358		

tablet every morning, hold for blood pressure less than 100, call physician if the systolic blood pressure is greater than 160 or diastolic pressure is greater than 90 at 7:00am.
-Verapamil 180mg was documented as administered daily from 08/01/20-08/31/20.
-There were no blood pressures documented, and it could not be determined if the resident was within parameters to receive the medication.

Review of Resident #4's September 2020 eMAR revealed:
-There was an entry for Verapamil 180mg one tablet every morning, hold for blood pressure less than 100, call physician if the systolic blood pressure is greater than 160 or diastolic pressure is greater than 90 at 7:00am.
-Verapamil 180mg was documented as administered daily from 09/01/20-09/16/20.
-There were no blood pressures documented, and it could not be determined if the resident was within parameters to receive the medication.

Observation of medication on hand for Resident #4 on 09/18/20 at 9:45am revealed:
-There was a bubble pack containing Verapamil 180mg dispensed on 09/04/20.
-There were 13 out of 38 tablets remaining in the bubble pack.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/23/20 at 11:41am revealed:
-The pharmacy had an order for Verapamil 180mg one tablet every morning dated 02/20/20 for Resident #4.
-A 28-day supply of Verapamil 180mg was dispensed on 07/03/20, 07/31/20 and 08/28/20.
-The Verapamil order had parameters to hold for blood pressure less than 100, call the physician if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 168	D 358		

the systolic blood pressure is greater than 160 or diastolic pressure is greater than 90.
-The pharmacy entered the order into the eMAR system, however did not include a space for the blood pressures in error.
-The facility also had the ability to include the blood pressure.
-There was no documentation the facility called to get the order adjusted on the eMAR to include space for blood pressures.

Interview with the medication aide (MA)/Floor Supervisor on 09/21/20 at 2:47pm revealed:
-She knew Resident #4 had an order for Verapamil 180 with blood pressure parameters.
-She checked Resident #4's blood pressure and recorded it on the eMAR before she administered Verapamil.
-She recorded the blood pressures on the eMAR.
-She was not sure why the blood pressures were not showing up on the eMAR.
-She thought the eMAR system was having some difficulties and did not retain the recorded blood pressures.
-There was no other place the blood pressures were documented.

Telephone interview with Resident #4's primary care provider (PCP) on 09/22/20 at 8:29am revealed:
-Resident #4 was ordered Verapamil 180mg to treat hypertension.
-Parameters were put in place for Verapamil to prevent the medication from being administered if the blood pressure was low.
-Administering Verapamil when the blood pressure was too low could cause Resident #4's blood pressure to become too low causing her heart to stop, cardiac arrest, dizziness, confusion, and increased falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 169 Interview with the Administrator on 09/21/20 at 2:35pm revealed: -She expected the MAs to check Resident #4's blood pressure prior to administering the Verapamil as ordered by the PCP. -She and the MA/floor supervisors were responsible for making sure there was an entry for blood pressures on the eMAR. -She and the MA/floor supervisors had access to review and put orders on the eMAR after the pharmacy entered the order. -She did not know there was no entry for blood pressures to be added for Resident #4's Verapamil. -MAs were responsible for notifying the MA/floor supervisors or her if there was not a space for blood pressures to be recorded on the eMAR. _____ The facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner related to Furosemide not administered as ordered contributing to the resident having shortness of breath upon exertion and edema which could result in heart failure (Resident #2); not receiving medications that were scheduled during the time of dialysis treatments 3 times weekly increasing the risk for high blood pressure (Resident #10); not having medication or nebulizer available for administration when needed (Resident #3) contributing to the resident having frequent symptoms of shortness of breath and going to the emergency room for shortness of breath and chest pain and receiving a blood pressure medication without her blood pressure being checked as ordered putting her at substantial risk for dizziness, increased falls, and cardiac arrest (Resident #4). This failure to ensure medications were available and administered as ordered by	D 358		

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 358	Continued From page 170 the prescribing provider placed residents at substantial risk for serious physical harm and neglect of residents would occur and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 21, 2020 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 30, 2020.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 5 residents sampled (#3) had physicians' orders to self-administer medications for topical throat spray.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 375	Continued From page 171 Review of Resident #3's current FL2 dated 12/30/19 revealed: -Diagnoses included allergic rhinitis, gastroesophageal reflux disease, and obesity. -There was an order for sore throat spray 1.4% 5 sprays every 2 hours as needed for sore throat, leave in for 15 seconds then spit. Review of Emergency Department (ED) documents for Resident #3 dated 08/07/20 revealed: -Resident #3's chief complaint was body aches, sore throat, chest pain, shortness of breath and cough. -There was an order for a phenol topical Chloraseptic 1.4% topical spray (a medication used to relieve sore throat) every 2 hours for 7 days. Observation of medication on hand on 09/18/20 at 9:45am revealed the medication was not on the medication cart. Interview with the medication aide (MA) on 09/22/20 at 8:30pm revealed he was not sure where the sore throat spray was located, he checked the medication cart and he checked overstock and it was not in the facility. A second interview with the MA on 09/22/20 at 8:41am revealed: -He asked Resident #3 about his throat spray and it was in his room. -He did not know why the medication was in his room. -He did not know until today that the medication was in his room. -He had not completed a cart audit to see if all medications were available for Resident #3.	D 375		

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D 375	Continued From page 172	D 375		

-The floor supervisors were responsible for completing the cart audits.
-He did not know if Resident #3 had an order to administer the medication independently.
-Resident #3 did not have an order to self administer the sore throat spray.
-He did not assist Resident #3 with the throat spray when he needed it.

Observation of the sore throat spray on 09/22/20 at 8:30pm revealed:
-The MA brought the sore throat spray out of the resident's room to the medication cart.
-The bottle was labeled as 6 fluid oz. with about one-fourth of the medication remaining in the bottle.
-The medication was in a bag labeled with the pharmacy label with the resident's name and instructions.
-The label indicated the sore throat spray was dispensed on 08/07/20.
-The label indicated the medication was to be administered one spray every 2 hours by mouth for 7 days.

Interview with Resident #3 on 09/23/20 at 12:30pm revealed:
-He kept the medication in his room to use when needed.
-He sprayed the medication whenever his throat hurt, "it helps me to breath better".
-I used it "last night and this morning".
-He did not spit the medication out after he let it sit for 15 seconds.
-He could not remember who gave him the medication to keep in his room.
-He had the bottle since he returned from the ED in August 2020.

Review of Resident #3's August 2020 electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 375	Continued From page 173 Medication Administration Record (eMAR) revealed: -There was an entry for sore throat spray 1.4% to be administered one spray every 2 hours for 7 days at 8:00am, 10:00am, 12:00pm, and 2:00pm. -Sore throat spray 1.4% was documented as administered daily at 8:00am, 10:00am, 12:00pm, and 2:00pm from 08/08/20-08/13/20. -There was a second entry for sore throat spray 1.4% to be administered one spray every 2 hours as needed leave in place 15 seconds and then spit. -There were no documented administrations for the "as needed" entry from 08/01/20-08/31/20. Review of Resident #3's September 2020 eMAR revealed: -There was an entry for sore throat spray 1.4% to be administered one spray every 2 hours as needed leave in place 15 seconds and then spit. -Sore throat spray 1.4% was documented as administered on 09/01/20 and 09/05/20, the results indicated the spray was effective. -There were no other documented administrations from 09/02/20-09/04/20, 09/06/20-09/15/20. Telephone interview with the pharmacist at the facilty's contracted pharmacy on 09/23/20 at 11:41am revealed: -Resident #3 was originally ordered sore throat spray 1.4% 5 sprays every two hours as needed on 12/23/19. -The medication ordered 12/23/19 had not been dispensed since the order was written. -The resident was then ordered sore throat spray 1.4% one spray every 2 hours for days on 08/07/20. -The pharmacy dispensed one 6 oz. bottle on 08/07/20 for Resident #3.	D 375		

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D 375	Continued From page 174 -Using too much sore throat spray could cause the throat to become too numb and cause choking. Interview with Resident #3's primary care provider (PCP) on 09/22/20 at 8:29am revealed: -She did not order the sore throat spray for the resident originally, however signed the order to continue medications that were in place prior to her becoming the PCP. -She expected the staff to administer the sore throat spray. -Due to the resident's intellectual disability, he would be at risk for self administering the medication incorrectly. Interview with the temporary Administrator and the Chief Operating Officer (COO) on 09/29/20 at 1:15pm revealed: -Medications were supposed to be administered as ordered. -She expected the MAs to administer the medication if the resident did not have an order to self-administer. -She did not know Resident #3 was administering his own medication in his room.	D 375		
D 376	10A NCAC 13F .1005 (b) Self-Administration Of Medications 10A NCAC 13F .1005 Self-Administration Of Medications (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not	D 376		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 376	Continued From page 175 imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure contact with the primary care provider (PCP) regarding changes in residents' condition related to the ability to self-administer medications, and resident non-compliance with the provider's orders for 3 of 5 sampled residents who self-administered medications (Residents #2, #12, and #1). The findings are: 1. Review of Resident #2's current FL2 dated 05/01/20 revealed: -Diagnoses included atrial fibrillation, cardiomyopathy, depression and urinary retention. -Self-administer medication orders included Systane eye drops, 1 drop in each eye 4 times a day as needed; Diclofenac 1% topical gel apply 1 gram to joints twice a day; Triple Antibiotic ointment apply to supra pubic catheter site 3-4 times daily as needed; and Anti-fungal powder 2% apply to perineum twice a day. -Resident #2's level of care included semi-ambulatory with a rollator and needed assistance with bathing. Review of Resident #2's record revealed a provider's order dated 05/28/20 for Systane	D 376		

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D 376	Continued From page 176 Complete 0.6% optical solution, 1 drop in both eyes, scheduled 4 times a day. Review of Resident #2's July, August and September 2020 electronic medication administration record (eMARs) revealed: -There was an entry for Diclofenac 1% topical gel, apply one gram to joints twice a day, may keep at bedside. -There was documentation the medication was self-administered. -There was an entry for Triple Antibiotic ointment, apply to supra pubic catheter site 3-4 times daily as needed. -There was documentation the medication was self-administered. -There was an entry for Anti-fungal powder 2%, apply to perineum twice a day. -There was documentation the medication was self-administered. -There was an entry for Systane 0.6% eye drops, instill one drop in both eyes, as needed, four times daily. -There was documentation the medication was self-administered. -There was no entry for Systane eye drops 0.6%, one drop in both eyes, scheduled four times daily. Observation of Resident #2's medications available for administration on 09/15/20 at 12:10pm revealed: -Resident #2 had a bedside table next to the head of the bed. -On top of the bedside table were a medication container with a bottle of Systane eye drops inside, and a bottle of generic nasal spray. -Neither the eye drops, or the nasal spray were labeled with directions for administration. -The Systane eye drop bottle was missing the cap, and the contents were exposed to air.	D 376		

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D 376	Continued From page 177	D 376		

-The Diclofenac gel, Antifungal powder and Antibiotic cream were not available for administration in Resident #2's room or in the medication cart.

Review of Resident #2's Care Plan dated 01/15/20 revealed:
-Resident #2 needed staff assistance cutting her meats at meals.
-She was independent in all other activities of daily living-ambulation, toileting, bathing, dressing and personal hygiene.

Review of Resident #2's Licensed Health Professional Support (LHPS) revealed:
-Resident #2's LHPS was completed on 07/07/20.
-She was alert and able to make her needs known.
-Tasks included ambulation with the use of an assistive device and position, empty and clean around the supra pubic catheter.

Review of the Home Health (HH) notes dated 07/06/20 and signed by the primary care provider (PCP) on 07/17/20 revealed:
-Skilled services were needed due to self-care deficit from prior level of function.
-This resulted in difficulty in ability to access shower, bathing safety, dressing, managing dyspnea, managing hygiene, managing toileting, self-management of conditions or illness.

Review of HH notes dated 09/04/20 revealed:
-Resident #2 was very lethargic during this assessment.
-She could not tell the skilled nurse her date of birth or name, which was out of her baseline.
-Resident #2 required staff assistance and used a rollator for mobility.
-She required frequent rest periods due to

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 376	Continued From page 178	D 376		

increased shortness of breath and poor endurance.

Interview with a MA on 09/15/20 at 10:10am revealed:
-Resident #2 preferred to take care of her own needs.
-She had not been notified of a change in Resident #2's personal care needs.

Observation of Resident #2 in her bedroom on 09/15/20 at 11:31pm revealed:
-Resident #2 was in her bed with eyes closed.
-Staff were changing her brief and resident moaned as she was turned and repositioned by staff.
-Abdominal area around the supra pubic catheter site was red and tender to the touch as staff provided care.
-There was some skin breakdown and a red rash in her perineum area.
-Resident #2 was weak and required staff assistance to raise herself to the side of the bed.
-Resident #2 needed coaxing and cues from surveyor and MA to ambulate with assistance of a rollator to the bathroom.
-Resident #2 stopped several times on the way to the bathroom in her room and stated she was tired and short of breath.

Interview with Resident #2 on 09/15/20 at 12:25pm revealed:
-Resident #2 was sitting on the side of her bed, rubbing her eyes and stating, "my eyes are itchy."
-Resident #2 complained to the staff she was unable to put her eye drops in her eyes and needed assistance.
-When asked where the cover for the eye drops was, or how long it had been missing, she did not know.

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 376	Continued From page 179 -She did not know how often the eye drops could be administered daily or when she last had the bottle refilled. -She did not know who ordered her eye drops when she needed a refill. -Resident #2 did not know where her Diclofenac gel was. She used the gel when her joints ached. -"It was here somewhere." -She remembered the antibiotic cream but could not remember how often to use it or when she last applied it to her catheter site. -Resident #2 remembered having a powder at some point but could not remember what it was used for. Telephone interview with the home health (HH) clinical staff on 09/17/20 at 4:01pm revealed: -During a scheduled visit with Resident #2, around the end of August, the HH Registered Nurse (RN) found the resident confused, lethargic and very different from her baseline. -In early August, Resident #2 was independent with personal care and ambulatory with her rollator. -She had always been meticulous in her personal care and appearance. -At present, Resident #2 was not independent with her personal care and hygiene and required assistance of staff when ambulating. Telephone interview with Resident #2's responsible family member on 09/18/20 at 2:32pm revealed: -She had advocated for a higher level of care for Resident #2. -She told the Administrator Resident #2 needed more assistance from the staff with her personal care. -Resident #2 needed more cueing and prompts for daily tasks.	D 376		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 376	Continued From page 180	D 376		

-Resident #2 had quite a cognitive decline in the past month.
-She had not spoken with Resident #2 on the phone, or received a text response from her since mid-August (08/18/20), which was very unusual.
-When she contacted the facility to determine why she had not been able to communicate with Resident #2 through her cell phone, the staff related Resident #2 did not want to talk to anyone.
-This was a big change in her behavior.

Telephone interview with the Ombudsman on 09/23/20 at 4:42pm revealed:
-She had been in contact with Resident #2 weekly for months.
-Resident #2 stated she needed more care than the staff was willing to provide.

Telephone interview with another MA on 09/25/20 at 1:24pm revealed:
-Resident #2 had trouble with her memory before she was ill in August.
-She could not identify the proper names for objects or use her phone.
-She was still not fully aware.
-She used to take showers independently and was able to take care of herself.
-Now she needs reminders and assistance from staff.

Telephone interview with Resident #2 on 09/24/20 at 11:44am revealed:
-She became short of breath when she ambulated with her walker. (Observed on 09/21/20 when ambulating with walker and talking).
-She had an inhaler and thought it was on the medication cart.
-The inhaler helped her when she was short of

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 376	Continued From page 181	D 376		

breath, but she usually forgot to ask for it.
-She used to weigh herself every day and put the weight on the calendar in her room.
-She had not weighed herself in a long time and was not sure what the information was used for.
-She used to empty her own catheter bag, however she needed the staff to assist now.
-Since she had been ill, she needed assistance walking and taking a shower.

Interview with a medication aide (MA) on 09/21/20 at 8:45am revealed Resident #2 informed the staff when she needed refills for the medications she self-administered.

Interview with the MA/Floor Supervisor on 09/21/20 at 10:30am revealed:
-When a resident had a self-administration order from their provider, staff ordered their medications when the resident requested a refill.
-The MAs reminded the residents who self-administered their medications to inform the staff when their medications were low.
- The MAs were responsible for checking their medication bottles periodically.
-The MA/Floor Supervisor, assigned to the specific floor, ordered medications as needed from the pharmacy.
-She did not know Resident #2's self-administer medications were not available to be administered.
-Resident #2 had not made her aware the medications needed to be refilled.
-She did not know when Resident #2's medications were last checked.
-Resident #2 was a very independent and private person.

Interview on at with the primary care provider (PCP) on 09/18/20 at 1:45pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 376	Continued From page 182	D 376		

-She was the PCP for Resident #2, but had not seen her since she was assigned to her caseload in July of 2020.
-She was not aware Resident #2 did not know the directions or times of administration for her medications, or the location of the Diclofenac gel, Antibiotic cream or Antifungal powder.
-In addition to requesting staff to assist her with the administration of her eye drops, and Resident #2 not recalling the Systane eye drops were changed from "as needed" to scheduled four times a day, an assessment of self-administration for this resident should be initiated by the staff.
-A request from the staff to discontinue Resident #2's self-administration order should be sent to the provider, and to date it had not been.

Interview with the Administrator on 09/21/20 at 2:30pm revealed:
-It was the responsibility of the MA/Floor Supervisor to order medications from the pharmacy that were not delivered monthly.
-The residents who self-administered medications should inform the MA when they need refill prescriptions.
-Sometimes Resident #2 did not speak to the staff.
-That could explain the reason the staff was unaware of the need to refill her medications.
-A request from the staff to discontinue Resident #2's self-administration order should have been sent to the provider, and to date it had not been.

A request was made on 09/21/20 at 2:30pm for the Self-Administration policy, but not provided by exit on 09/30/20.

A request was made on 09/21/20 at 2:30pm for Resident #2's quarterly self-administration assessment but was not provided by exit date on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 376	Continued From page 183 09/30/20. Refer to interview with the Administrator on 09/21/20 at 2:30pm. Refer to interview with the Administrator of a sister community on 09/21/20 at 2:30pm. 2. Review of Resident #12's current FL2 dated 02/17/20 revealed: -Diagnoses included dementia, high cholesterol, hypertension and vitamin D deficiency. -There was an order for Dorzolamide/Timolol eye drops, instill 1 drop in both eyes twice a day-wait 3-5 minutes between different eye drops-may keep in room and self-administer. -There was an order for Latanoprost 0.005% eye drops, instill 1 drop in the right eye at bedtime-wait 3-5 minutes between different eye drops-may keep in room and self-administer. -Resident #12 was documented as constantly disoriented. Review of Resident #12's July, August and September 2020 electronic medication administration record (eMARs) revealed: -There was an entry for Dorzolamide/Timolol eye drops, 1 drop in both eyes twice a day, wait 3-5 minutes between different eye drops. May keep in room and self-administer. -There was documentation the Dorzolamide eye drops were self-administered. -There was an entry Latanoprost 0.005%, instill 1 drop in the right eye at bedtime, wait 3-5 minutes between different eye drops. May keep in room and self-administer. -There was documentation the Latanoprst eye drops were self-administered. Observation of Resident #12's medications	D 376		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 376	Continued From page 184	D 376		

available for administration on 09/16/20 at 10:55am revealed:
-Resident #12 was sitting in a chair in her room, pleasantly talking to herself.
-Staff checked the cabinets and drawers in Resident #12's room, as well as the bathroom, and could not locate any medications.
-There was a medication container with a pharmacy generated label listing Resident #12's name and Dorzolamide/Timolol eye drops, located on the 3rd floor medication cart across from the nurses' station.
-The directions were to instill 1 drop in both eyes twice a day-wait 3-5 minutes between different eye drops, may keep in room and self-administer.
-The dispensed date on the pharmacy label was 07/20/20.
-The plastic seal over the cap of the Dorzolamide eye drop bottle was intact and unopened.
-There was a second medication container, located in the same medication cart, with a pharmacy generated label listing Resident #12's name and Latanoprost 0.005% eye drops.
-The directions were to instill 1 drop in the right eye at bedtime-wait 3-5 minutes between different eye drops, may keep in room and self-administer.
-The dispensed date on the pharmacy label was 07/20/20.
-The plastic seal over the cap of the Latanoprost eye drop bottle was intact and unopened.
- "Self-Administer" was handwritten on both medication pouches containing the Dorzolamide and Latanoprost eye drops.

Interview with the medication aide (MA) on 09/21/20 at 8:45am revealed:
-Medication cart audits were performed monthly by the MA/Floor Supervisor.
-The medication cart audits were documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 376	Continued From page 185	D 376		

and placed in a binder.
-The MA/Floor Supervisors ordered medications that were low or not included with the monthly delivery.
-Residents who self-administer medications either informed the staff when they needed a refill, or the family provided.
-Resident #12 kept her eye drops in her room and staff re-ordered them every 3 months.
-She had seen Resident #12 self-administer her eye drops recently.

Interview with Resident #12's mental health provider (MHP) on 09/21/20 at 9:30am revealed:
-Resident #12 had advanced dementia and was delusional and extremely paranoid.
-Resident #12 was combative with the staff when they attempted to administer her medications.
-Due to her combativeness, it was determined she might be more compliant with her medications if she self-administered them.
-Facility staff faxed a resident list 1-2 days before she came into the facility. The facility had a chance to write down any concerns they had for her to review regarding her residents.
-She had not been informed of any staff concerns regarding medication administration for Resident #12.
-At this time, with her advanced dementia and aggressive behaviors, it would not be safe for Resident #12 to keep her medications in her room or self-administer them as ordered.

Interview with MA on 09/21/20 at 8:20pm revealed:
-Resident #12 had come out of her room swinging her cane and coming toward staff when they tried to enter her room.
-That was not unusual behavior for her.
-That was the reason she self-administered her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 376	Continued From page 186	D 376		

medications.

Telephone interview with the primary care provider (PCP) on 09/24/20 at 4:10pm revealed:
-Resident #12 should not be self-administering her medication because she was very confused.
-It was very difficult for her to review the eMARS for the residents electronically.
-Resident #12 had been diagnosed with glaucoma.
-Dorzolamide and Latanoprost were prescribed to keep the pressure in her eye from increasing.
-Without the administration of the eye drops, the pressure in Resident #12's eye would become increasingly worse and she would experience a visual deficit.

Interview with Resident #12's power of attorney (POA) on 09/24/20 at 12:00pm revealed:
-Resident #12 had been a resident at the facility for over 5 years.
-For the past 2 and 1/2 years she had declined quickly, and in the last 18 months her dementia had accelerated.
-Resident #12 had eye drops prescribed for a diagnosis of glaucoma.
-Prior to the quarantine, she visited 2-3 times a week and took care of her personal needs, including assisting her with the administration of her eye drops.
-Approximately 9 months ago, she noticed Resident #12 was not competent to administer her eye drops and medications.
-Resident #12 did not understand the directions to the eye drops, or how to administer them.
-She reviewed the medication instructions several times with Resident #12, but the resident just did not understand the directions.
-When the quarantine was initiated, she forgot to follow up with the staff regarding Resident #12's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D 376	Continued From page 187 inability to administer her own eye drops. Telephone interview with the MA/Floor Supervisor on 09/25/20 at 1:24pm revealed: -If the staff was concerned a resident was not able to continue to self-administer their medications, staff would contact the PCP. -Resident #12 did not really understand her medications. -Currently she had 2 eye drops on her medication profile. -She thought the provider had been made aware of her inability to continue to self-administer her medications. -She had not contacted the provider regarding Resident #12's ability to continue self-administering her medications. Telephone interview with the pharmacist from the facility's contracted pharmacy on 09/25/20 at 4:10pm revealed: -Dorzolamide/Timolol eye drops instill 1 drop in both eyes twice a day, may keep in room and self-administer, was dispensed on 06/18/20 and 07/20/20. -Latanoprost 0.005% eye drops instill 1 drop in the right eye at bedtime, may keep in room and self-administer, was dispensed on 06/18/20 and 07/20/20. Based on observations, interviews and record reviews it was determined Resident #12 was not interviewable. A request was made on 09/21/20 at 2:30pm for the Self-Administration policy, but not provided by exit on 09/30/20. A request was made on 09/21/20 at 2:30pm for Resident #2's quarterly Self Administration	D 376		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 376	Continued From page 188	D 376		

assessment but was not provided by exit date on 09/30/20.

Refer to interview with the Administrator on 09/21/20 at 2:30pm.

Refer to interview with the Administrator of a sister community on 09/21/20 at 2:30pm.

3. Review of Resident #1's current FL2 dated 08/13/19 revealed:
-Diagnoses included diabetes, osteoarthrosis, cervical spondylosis.
-There were physician orders for may self-administer medications and keep medication in room.
-Self-administer medication orders included Artificial tears 1 drop both eyes daily, ProAir inhaler 108 mcg 2 puffs 4 times daily, Refresh eye drops 1 drop in both eyes daily, Gaviscon take 1 tablet every 6 hours as needed, Senna take 2 tablets at bedtime as needed, and Advair 100/50 inhaler take 1 puff daily and rinse mouth after use, and Tylenol PM extra strength 25-500mg tablet take 1 tablet at bedtime

Interview on 09/15/20 at 10:55am with Resident #1 revealed:
-She was sick for 14 days with COVID-19.
-She self-administered the medications that were in her room.
-"Sometimes I could not administer my medications because I was so weak."
-The MAs would come in the room and give her some medications everyday but then she would not see them again.

Observation on 09/15/20 at 10:55am of Resident #1's medications on hand in the resident's room revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 376	Continued From page 189 -Resident #1 had a bedside table next to her bed. -On top of the bedside table was a generic brand of saline drops, there was no pharmacy generated label on the eye drop for instruction on how and when to administer. -The top drawer of the bedside table was halfway opened. -Inside the drawer was a bottle of Tussin Dm, Gaviscon, Tylenol PM, Triple Antibiotic ointment, and another box of generic brand saline solution. -There were no pharmacy generated labels for directions on how to use on any of the medications found in the bedside table drawer. -Three medications had hand written [Resident #1's] name, the Tussin Dm, Gaviscon and the generic eye solution. -Two of the medications did not have Resident #1's name on them, the Tylenol PM and the Triple Antibiotic ointment. -In the bottom of the drawer, Resident #1 pulled a plastic bag with 2 inhalers inside the bag. -One was a BREO 200mcg/25mcg inhaler that was not labeled but had a pharmacy generated label on the plastic bag inhaler 2 puffs once daily; the other inhaler was labeled ProAir 108mcg inhaler 2 puffs by mouth every 6 hours as needed. Review of Resident #1's record revealed: -There was no documentation of a self-administration medication assessment due to Resident #1 unable to perform self administration due to testing positive for COVID-19 and for 14 days she was unable to administered her medications. -Staff documented on the electronic Medication Administration Records (eMARs). A request was made on 09/21/20 at 2:30pm for the Self-Administration policy, but not provided by	D 376		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 376	Continued From page 190 exit on 09/30/20. A request was made on 09/21/20 at 2:30pm for Resident #1's quarterly Self Administration assessment but was not provided by exit date on 09/30/20. Refer to interview with the Administrator on 09/21/20 at 2:30pm. Refer to interview with the Administrator of a sister community on 09/21/20 at 2:30pm. _____ Interview with the Administrator on 09/21/20 at 2:30pm revealed: -She was not aware of a facility policy regarding residents who self administer their medications. -The medicaion aide (MA)/floor supervisor ordered the residents medications through the contracted pharmacies. -It was the responsibility of the MA/Floor Supervisor to ensure all medications ordered for the residents were filled and in the building for administration. Interview with the Administrator of a sister community on 09/21/20 at 2:30pm revealed: -Residents who self administered their medications were assessed quarterly of competency. -The MA/Floor Supervisor completed the assessment tool and send to the primary care physician. -The physician makes the determination of competency regarding the resident's ability to self administer their medications. _____ The failure of the facility to contact the provider,	D 376		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 376	Continued From page 191 regarding the non compliance of residents who self administered medications and treatments, due to a change in condition which affected the ability of the resident to self administer (Resident #12, #2 and #1) and placed a resident at risk for visual deficits in not receiving scheduled eye drops (Resident #12); a risk for an eye infection and skin infection around the catheter site and perineal area (Resident #2); and not ensuring the proper labeling and directions were provided for medications kept in the resident's room (Resident #1). This failure was detrimental to the health and safety of these residents and constitutes a B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 25, 2020 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 14, 2020.	D 376		
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 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	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 451	Continued From page 192	D 451		

facility failed to 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 resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid for 2 of 9 sampled residents (Resident #2 and #9).

The findings are:

Review of the facility's fall policy revealed when a fall occurs an incident report will be completed.

A request was made on 09/15/20 at 9:45am, on 09/21/20 at 12:08pm and on 09/22/20 at 5:55pm for incident reports for Resident #2 and #9. There were no incident reports provided by exit date on 09/30/20.

1. Observation of Resident #2 on 09/15/20 at 11:30pm revealed:
-Resident #2 was in bed with her eyes closed.
-As staff provided care to Resident #2, three bruises were noted on her left side.
-There was a yellowish/purple bruise above her left eyebrow, approximately 1.5 inches in length.
-There was a purple bruise on Resident #2's left thigh approximately the size of a fifty cent coin.
-There was a purple bruise on Resident #2's left knee, approximately the size of a quarter coin.

Interview with Resident #2 on 09/15/20 at 12:10pm and on 09/16/20 at 7:45am revealed:
-She remembered she had fallen out of the bed, but could not remember when.
-She tried to get up from the floor, but was unable.
-Her call bell was not within her reach.
-She did not remember how long she was on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 451	Continued From page 193	D 451		

floor-"it seemed like a long time."
-She was found by staff on the floor.
-She does not remember if she called out for help or how the staff found her.

Interview with Resident #2's home health (HH) Registered Nurse (RN) on 09/16/20 revealed:
-During her scheduled visit on 09/07/20, the RN observed bruising above Resident #2's left eye, left thigh and left knee.
-Staff did not know Resident #2 had bruising above her left eye.
-Staff had not received a report from the previous shift that Resident #2 had a fall or an incident.
-There was no documentation of a fall in Resident #2's progress notes.
-There was no documentation of an incident report completed for Resident #2.
-The RN reported Resident #2's to the HH staff (Physical Therapist) who was responsible for reporting all information regarding the residents to the Administrator at the end of the day.
-On 09/07/20, the HH staff contacted the primary care physician (PCP) in the presence of the Administrator, and received orders to obtain a urinalysis to rule out a urinary track infection (UTI) and a skull X-Ray to determine any abnormalities due to the fall.

Telephone interview with Resident #2's PCP on 09/18/20 at 1:45pm revealed:
-On 09/07/20, she was informed by the HH Physical Therapist that Resident #2 had a fall and was observed to have bruising above her left eye, left thigh and left knee.
-The Physical Therapist did not know when the fall had occurred since there was no documentation provided.
-The PCP had not been informed, by the facility staff, Resident #2 had a recent fall or injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

(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 194 -She ordered a urinalysis to rule out a UTI and a skull X-Ray to determine any abnormalities due to the fall. -She reported the skull xrays were negative and the urinalysis was positive for a UTI. -She expected the facility to notify her when a resident falls or has an injury. Telephone interview with Resident #2's Responsible Family Member on 09/18/20 at 2:32pm revealed: -She had advocated for a higher level of care for Resident #2. -She told the Administrator Resident #2 needed more help with personal care and catheter care. Telephone interview with the MA/Floor Supervisor on 09/25/20 at 1:45pm revealed: -On 09/03/20, as she was administering her 12:00pm medications, she observed Resident #2 sitting on the floor beside her bed. -Resident #2 reported she had fallen out of her bed and toppled on her left side. -Resident #2 had attempted to get up but was unable. -The MA/Supervisor observed a "red mark on her forehead". -She contacted the provider on 09/03/20 and completed an incident report. -The PCP ordered skull X-Rays and a urinalysis for Resident #2. Interview with the Administrator on 09/21/20 at 3:00pm revealed: -She was not aware Resident #2 had fallen recently. -On 09/16/20 she observed Resident #2's bruising while staff provided personal care. -She did not know the PCP had ordered skull xrays.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 451	Continued From page 195	D 451		

-She did know Resident #2 had a UTI.
-She was not able to produce Resident #2's incident report for the fall.

A request was made on 09/21/20 at 2:30pm for Resident #2's skull xrays results but was not provided by exit on 09/30/20.

Review of the facility's incident and accident reports faxed to the county Department of Social Services (DSS) revealed there was no incident report faxed for Resident #2.

Refer to interview with a medication aide on 9/18/20 at 8:35am.

Refer to interview with the Administrator on 09/21/20 at 2:25pm and 3:00pm.

2. Review of Resident #9's current FL2 dated 03/03/20 revealed:
-Diagnoses include dementia, diabetes, hypertension and anxiety.
-Documentation Resident #9 was ambulatory.
-Documentation Resident #9 was incontinent of bowel and bladder.
-Documentation skin was normal.

Review of Resident #9's facility care notes revealed:
-On 09/03/20 at 9:00am, Resident #9 was seen on the floor without injuries. The Power of Attorney (POA) was called. Vital signs were obtained: B/P 136/87, pulse 91, respirations 18 and temperature 97.3.
-On 09/07/20 at 8:22am, Resident #9 had bruising to the forehead and right arm. Vital signs were obtained; B/P 166/76 and temperature 98.1.
-On 09/07/20 at 2:32pm, the personal care aide (PCA) noticed Resident #9 had bruising on the

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 451	Continued From page 196 right hip with skin tear on right shoulder. Telephone interview on 09/28/20 at 1:15pm with a medication aide (MA) revealed: -The facility policy was if a resident fell an incident report was to be completed: if the resident hit their head they were to be sent to the emergency room for an evaluation. -Resident #9 required 2-person assist with transfers. -She had worked on 09/03/20 when Resident #9 was found on the floor in her room. -Resident #9 was found on her knees. -Resident #9 did not have any injuries, skin tears or bruising. -The MA and the PCA placed Resident #9 back in her bed. -She contacted Resident #9's physician and the family. -She completed an incident report on 09/03/20 and placed the report in Resident #9's record. -She reported to the next shift Resident #9 had fallen without injury. -She again worked on 09/07/20 when the PCA noticed Resident #9 had bruising and skin tears to her right shoulder, right hip, and her forehead. -She informed the Administrator and the MA/Floor Supervisor of the bruising and the skin tears and had them look at Resident #9's skin tears and bruising. - "No one knows what happened to [Resident #9]." -There was no documentation Resident #9 had fallen. -She contacted Resident #9's primary care provider (PCP) to inform him of the bruising and skin tears. -The PCP ordered a skull x-ray series and a right hip x-ray. -She had ordered Resident #9's x-ray STAT	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D 451	Continued From page 197	D 451		

(immediately) because she was worried something was wrong.
-She completed an incident report for Resident #9 on 09/07/20 because of the injury to the head, hip and the shoulder.
-She placed the report in Resident #9's record.
-Resident #9's x-ray for the skull and the hip were negative.
-She was not responsible for faxing the report to DSS, that was the responsibility of the Administrator.

Interview on 09/21/20 at 2:25pm with the Administrator revealed:
-Resident #9 was bedbound and required more care.
-She was unsure how Resident #9 received the bruising to her forehead, hip and shoulder and the skin tears documented on 09/07/20.
-She knew Resident #9's PCP ordered a skull x-ray series and a right hip x-ray on 09/07/20 due to the concerns of bruising to her head, hip, shoulder and the skin tears.
-There was no incident report sent to DSS after the x-ray was obtained.

Review of the facility's incident and accident reports faxed to the county DSS revealed there was no incident report faxed for Resident #9.

Refer to interview with a medication aide on 9/18/20 at 8:35am.

Refer to interview with the Administrator on 09/21/20 at 2:25pm and 3:00pm.

Interview with a medication aide on 9/18/20 at 8:35am revealed the MAs have to get approval from the Infection Control Manager and the

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 451	Continued From page 198 physician before they could send residents out to the hospital. Interview with the Administrator on 09/21/20 at 2:25pm and 3:00pm revealed: -The MAs and the floor supervisors were responsible for completing incident reports. -She would go into resident's room and speak to the resident and take vitals for any incident or accident. -She would send residents out to emergency department (ED) if resident requested. -She did not call the Chief Operating Officer (COO) if a resident needed to be sent out to the ED. -She called 911 if a resident needed to be sent out to ED.	D 451		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to personal care and other staffing, medication administration, self-administration of medications, and implementation. . The findings are:	D912		

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D912	Continued From page 199 1. Based on observations, interviews and record reviews, the facility failed to ensure the minimum number staff were always present to meet the needs of residents for 20 of 39 shifts sampled for 13 days between 09/02/20 and 09/14/20, which resulted in a lack of adequate staff required to provide personal care such as bathing, toileting, catheter care, skin care, dressing assistance, feeding assistance and grooming. [Refer to Tag 0188, 10A NCAC 13F .0604 Personal Care And Other Staffing (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 4 of 9 sampled residents (Resident #2, #10, #3, and #4) related to not administering a diuretic and a scheduled pain medication, and not having available for administration medications for allergies, acid reflux, and a hand held inhaler for shortness of breath (Resident #2); not administering a blood pressure medication, a medication for nerve pain and a phosphate binder three times a week while at dialysis treatment (Resident #10); not having a nebulizer medication available for use for shortness of breath (Resident #3) and not administering a blood pressure medication (Resident #4). [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to ensure contact with the primary care provider (PCP) regarding changes in residents' condition related to the ability to self-administer medications, and resident non-compliance with the provider's orders for 3 of 5 sampled residents who self-administered medications (Residents #2,	D912		

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D912	Continued From page 200 #12, and #1). [Refer to Tag 0376, 10A NCAC 13F .1005(b) Self-Administration Of Medications (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, operations, and policies of the facility were implemented and rules were maintained for housekeeping and furnishing, other requirements, personal care and other staffing, resident assessment, personal care and supervision, health care, resident rights, medication administration, self administration of medications, and reporting of accidents and incidents. [Refer to Tag 0980, G.S. 131D-25 Implementation (Type A1 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all residents were free from physical abuse and neglect related to personal care and supervision, health care, and resident rights. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 5 of 10 sampled	D914		

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D914	Continued From page 201	D914		

residents (Resident #2, #9, #1, #7 and #17) including catheter care and personal care with showers and general hygiene (Resident #2); care for a strong smell of urine, a saturated incontinent brief, and multiple wounds (Resident #9); personal care and bathing (Resident #1); assistance with bathing, dressing, and incontinent care (Resident #7); and assistance with grooming, bathing, and dressing, as indicated in the Care Plan (Resident #17). [Refer toTag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A1 Violation)].

2. Based on observations, interviews and record reviews the facility failed to ensure referral and followup to health care providers for 5 of 10 sampled residents (Resident #6, #9, #2 #10, and #3) regarding stomach pain, not feeling well, and not eating (Resident #6); a fall with injury to head and hip, multiple wounds and loss of weight (Resident #9); reporting of daily weights with parameters (Resident #2); medication refusals (Resident #10); and reporting of daily weights with parameters (Resident #3) [Refer toTag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].

3. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to practicing infection control procedures to reduce the risk of transmission and infection, including administration of medications following infection

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D914	Continued From page 202 control measures, COVID-19 positive staff working with non-COVID-19 residents, screening of staff and essential visitors, practicing social distancing while in the smoking area, and staff wearing appropriate personal protective equipment (PPE) and practicing social distancing requirements. [Refer toTag 338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)].	D914		
D917	G.S. 131D-21(7) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 7. To receive a reasonable response to his or her requests from the facility administrator and staff. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to respond to residents request for 4 of 9 sampled residents (Resident #6, #1, #4 and #19) with request for a medical evaluation (#6), a resident requesting personal care assistance when diagnosed with COVID-19 (#1), a resident requesting to be sent to the emergency department (#19), and a resident requesting staff assistance to make telephone calls to a family member (#4). The findings are: 1. Review of Resident #6's current FL2 dated 06/17/20 revealed diagnoses included chronic obstructive pulmonary disease (chronic lung disease), atrial-fibrillation (abnormal heart rhythm), hypertension and history of takosubo (heart failure). Review of Resident #6's care notes revealed: -On 09/09/20 at 2:00pm Resident #6 requested	D917		

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D917	Continued From page 203 "a sick tray" for supper. She stated, "her ulcer was bothering her and it acts up from time to time." -Resident #6 requested broth because it "usually helps her." -On 09/12/20 at 8:30pm Resident #6 stated "her ulcer and hernia in her belly was bothering her." -She did not feel well and requested to go the ED. Interview with a medication aide (MA) on 09/15/20 at 11:15am revealed: -She knew Resident #6 was "not feeling well" on 09/09/20. -Resident #6 was not eating much. -She had not contacted Resident #6's physician in regard to her not eating much and not feeling well. Interview with a personal care aide (PCA) on 09/16/20 at 3:00pm revealed: -On 09/11/20 and on 09/12/20 Resident #6 was laying around and was not her usual self. -Resident #6 was lying in bed and covered her head with the bedcovers. -Resident #6 requested a sick tray on both days, which consisted of broth and liquids. -She reported to the MA Resident #6 was not feeling well and not eating on 09/11/20. Interview with another PCA on 09/17/20 at 3:05pm revealed: -On 09/10/20, Resident #6 complained of stomach pain. -Resident #6 was lying in bed all day, "she was not feeling well." -Resident #6 was "not eating much." -She had told the MA on 09/10/20 Resident #6 was not feeling well. Interview with a MA/ Floor Supervisor on 09/15/20	D917		

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D917	Continued From page 204	D917		

at 10:40am revelaed:
-On 09/09/20, she noticed Resident #6's eating patterned had changed.
-Resident #6 requested broth for 2 days.
-She said her "ulcer was acting up."
-On 09/12/20 she requested cereal for breakfast and not her regular meal.
-Resident #6 said her "hernia was bothering her."
-She sent Resident #6 to the ED on 09/12/20 second shift, because she complained of stomach pain.

Review of Resident #6's Emergency Department (ED) physician note dated 09/13/20 revealed:
-Resident #6 chief complaint was nausea and vomiting for 2 weeks; had not eaten since last Friday and kept throwing up. Resident #6 had complained of abdominal pain off and on for 2 weeks more on the right side.
-The computed tomography (a diagnostic imaging test) (CT) of the abdomen and pelvis revealed ascending colonic mass with possible ruptured, metastatic liver lesions; recommendation of surgery consult.

Telephone interview with Resident #6's friend on 09/17/20 at 11:30am revealed:
-He contacted the Department of Social Services Adult Home Specialist (AHS) on 09/14/20.
-Resident #6 had called him on 09/07/20 and complained of not feeling well and not eating much since 09/04/20.
-On 09/09/20 Resident #6 called and told him she wanted to go to the hospital.
-Resident #6 told him the Administrator came to her room to look at her, the Administrator told Resident #6 she did not need to go the hospital.
-He was not sure if the Administrator was a medical provider or a nurse to make the call of not sending a resident out to the emergency

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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D917	Continued From page 205	D917		

department.
-Resident #6 was sick for over a week and the facility would not send her out.

Telephone interview with a second friend on 09/18/20 at 10:24am revealed:
-Resident #6 had called and told her she had not eaten in 8 days.
-Resident #6 knew she was sick.
-Resident #6 told her the staff at the facility came into her room and said, so you want to see a doctor in the hospital.
-"I think she did ask to go out to the hospital, and they were not sending her."

Interview with the Administrator on 09/16/20 at 11:00am revealed:
-She was not a nurse.
-Staff made her aware on 09/09/20 Resident #6 was not feeling well and not eating much.
-She had gone to Resident #6's room on 09/09/20 to see her.
-Resident #6 said, "she was ok."
-Resident #6 said, "I am fine."
-Resident #6 told the Administrator she could not keep anything down.
-Resident #6 told the Administrator she did not have a sore throat.
-Resident #6 told the Administrator, "It was her hernia acting up."
-On 09/10/20, she saw Resident #6 again in her room.
-Resident #6 said she ate all her breakfast and requested soup for lunch.
-On 09/11/20, Resident #6 told her she was constipated.
-On 09/12/20 she saw Resident #6 again and she requested soup for lunch.

Review of Resident #6's hospital discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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(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
D917	Continued From page 206	D917		

summary dated 09/16/20 revealed:
-Resident #6 was admitted to the Intensive Care Unit (ICU).
-Resident #6 was told she had a colon mass with possible rupture and metastatic liver lesions.
-She declined to tell her family of the CT findings at that time but requested to talk to a [named] facility staff person.
-The ER doctor called the facility and requested to talk that staff person.
-The ER doctor was placed on hold for 30 minutes.
-The staff at the facility could not locate the staff person Resident #6 requested to talk to.

Telephone interview with the nurse at Resident #6's doctor office on 09/22/20 at 10:15am revealed there was no documentation the facility had contacted the office on 09/09/20 through 09/16/20 in regard to Resident #6"s stomach pain, not eating or not feeling well.

Review of Resident #6's hospital notes dated 09/16/20 revealed Resident #6 died on 09/16/20 under comfort care while in the hospital.

2. Review of Resident #1's current FL2 dated 08/13/19 revealed:
-Diagnoses included diabetes, osteoarthritis, cervical spondylosis.
-Resident was semi-ambulatory.
-Resident was incontinent of bladder and continent of bowel.
-Resident required assist with her bathing and dressing.
-Functional limitations included sight.

Interview with Resident #1 on 09/15/20 at 10:55am revealed:
-She tested positive for COVID-19 and resided on

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D917	Continued From page 207	D917		

the third floor.
-She had been sick and weak and could not provide personal care to herself when she had COVID-19.
-During the facility's quarantine for COVID-19 staff would not come in her room to assist with personal care, bathing or changing her gowns.
-"I went 14 days without a shower or bath."
-"Staff were rude to me when I ask for help."
-"The Administrator would not talk to me."
-"Staff would bring my pills in the morning and then I would not see anyone else."
-"The only time I had my linens changed was when I had an accident in bed, they had to change them."
-She called her family daily and told them she was sick and needed help.
-"I kept asking the staff to call my doctor, I was sick."

Telephone interview with Resident #1's Power of Attorney (POA) on 09/18/20 at 10:05am revealed:
-Resident #1 called her daily to tell her she was weak, not feeling well and was sick.
-Resident #1 told her she had not had a shower or bath in 14 days.
-Resident #1 said she did not have linens changed during the COVID-19 pandemic for 10 to 14 days.
-Resident #1 complained of diarrhea on several occasions.
-"She [Resident #1] kept asking for help, but the staff did not give her any help."
-The POA tried calling the Administrator multiple times, but the Administrator would not talk to her.
-She left messages with the Administrator but never received any calls back.
-"You cannot imagine how I felt being 2 hours away from [Resident #1] and I could do nothing."

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	HAL013044	A. BUILDING: _____ B. WING _____	C 09/30/2020

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THE LIVING CENTER OF CONCORD	160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027

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D917	Continued From page 208 -The treatment Resident #1 received from there staff was unacceptable and cruel. -Resident #1 was so weak at times she could not understand her. -After multiples attempts of trying to reach out to the facility, I called the corporate office to complain about the treatment and care for Resident #1. -A person from corporate returned my call and had been updating me since my complaint about Resident #1's treatment. -"I do not trust the staff to care for Resident #1, but where I can I put her since she was COVID-19 positive." -"My heart was broken, and I cried to think no one was caring for Resident #1." -"I felt helpless." Interview on 09/16/20 at 11:00am with the Administrator revealed: -The residents who tested positive for COVID-19 were moved to the 3rd floor on the back-hall way. -She knew Resident #1 tested positive for COVID-19. -Resident #1 was alert and oriented. -The third floor was staffed accordingly to provide care for the residents during the COVID-19 outbreak in the facility. -She was not aware Resident #1 complained of not feeling well and requested to go the doctor when she had COVID-19. -She did not know Resident #1 went 14 days without a shower or bath. -She was not aware staff were not providing Resident #1 with personal care during those 14 days. -Resident #1 contacted her family every day. -She did not know Resident #1 family had requested call backs when they contacted her office.	D917		

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D917	Continued From page 209 -Resident #1 family had contacted Corporate office and the Chief Operating Officer (COO) was now communicating with the family on Resident #1's care. Telephone interview on 09/28/20 at 2:40pm with the COO revealed: -Resident #1's POA contacted the cooperate office. -She was now in communicating with the family to update them on Resident #1's care provided by the facility staff. 3. Interview with Resident #4 on 09/15/20 at 11:05am revealed: -She had a cellphone in her room that she could use to contact her family. -She had all of her family's phone numbers in a binder in her nightstand. -She was not sure if she needed assistance with using her cellphone. -If she needed assistance with her phone, she could use her call bell, however she was not sure where it was located. -She thought she knew how to use her cellphone, but she could not remember. -She would like for staff to assist her when needed. -She could not remember the last time she spoke to her family. Observation of Resident #4's room on 09/15/20 at 11:05am revealed her cellphone was on the charger on the nightstand. Interview with the Resident #4's responsible party (RP) on 09/16/20 at 11:46am revealed: -He had issues with communicating with the resident since the COVID-19 pandemic had occurred.	D917		

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D917	Continued From page 210 -The policy the facility had put in place was too restrictive regarding communication, "it is like my [family member] does not exist". -Resident #4 had a cellphone that could be used to contact family when needed, however she needed staff assistance to use the phone. -The facility was doing video calls at one time and it was stopped by the Administrator stating that "you could only use an Apple device to make calls", and "we don't have an Apple device". -He tried to arrange telephone calls with the resident and was told by the Administrator that the only times staff would be available to assist Resident #4 with phone calls was 9am-11am and 2pm-4pm once per week per family, and that was not always convenient. Interview with the Chief Operating Officer (COO) on 09/29/20 at 1:15pm revealed: -They were aware Resident #4's family had concerns about communication. -The family asked for the facility to provide assistance with the cellphone when needed. -"We told them we would do our best". -Times were offered to the family for to communicate with Resident #4. 4. Review of Resident #19's current FL2 dated 08/08/20 revealed diagnoses included asthma, emphysema and substance abuse. Interview with Resident #19 on 09/22/20 at 8:40pm revealed: -Resident #19 reported he woke this morning with a swollen tongue, and it was stuck to the roof of his mouth. -He had a rash on both his inner thighs the width of a handprint, deep red around the perimeter, lighter red as it approached the center.	D917		

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D917	Continued From page 211	D917		

-The rash was itching and burning.
-He had requested to be seen by his provider or sent out to the emergency department (ED) since this morning when he woke, "at around 7:30am".
-Staff on first shift told him, "you had to be dying to be sent out."
-Resident #19 was informed by staff the provider was contacted that morning and were waiting for a reply back.
-Each time he inquired as to the provider's recommendation he was told by staff they were waiting for the provider to return their call.
-At 8:40pm, Resident #19 requested, "please ask the Administrator if I can go out to the ED to be seen".
-The Administrator arrived shortly after 8:40pm, and the Administrator was notified of Resident #19's request to be sent out to the ED for evaluation.
-The Administrator stated she would have to review the progress notes and his medications, and determine when the provider was contacted.
-The Medics arrived at 9:20pm and brought Resident #19 to the ED for evaluation.

Telephone interview with a medication aide (MA) on 09/29/20 at 4:00pm revealed:
-She worked from 11:00am-6:00pm on 09/22/20.
-Resident #19 had requested, to the staff, to be sent to the ED for evaluation regarding what he thought was an allergic reaction.
-He said his tongue was swollen and he had a rash on his legs.
-She responded that he "would not be able to talk so much if his tongue was swollen".
-She knew the MA who administered the medications earlier that day was aware of his concerns and had administered Benadryl to Resident #19.
-She asked the oncoming staff (7:00pm-7:00am)

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D917	Continued From page 212 to contact Resident #19's primary care provider (PCP) with Resident #19's health concerns. -She did not know if anyone contacted the provider regarding Resident #19's health concerns. Telephone interview with the PCP on 09/29/20 at 4:35pm revealed: -She was never notified Resident #19 requested to be seen by a physician at the ED on 09/22/20 due to a possible allergic reaction. -She was never notified that he had been sent to the ED on 09/22/20 or the results of the visit.	D917		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, operations, and policies of the facility were implemented and rules were maintained for housekeeping and furnishing, other requirements, personal care and other staffing, resident assessment, personal care and supervision, health care, resident rights, medication administration, self administration of medications, and reporting of accidents and incidents.	D980		

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D980	Continued From page 213 The findings are: Interview with the Administrator on 09/16/20 at 11:00am revealed: -The third floor was designated as the COVID-19 floor during the outbreak. -Residents on the third floor were both COVID-19 positive and negative, the COVID-19 positive were placed on the back hallway. -She did not know residents were cleaning there own rooms and bathroom during the COVID-19 quarantine in the facility. -She was not aware residents were not getting baths, showers or personal care during the COVID-19 quarantine. -She was not aware residents did not have clean linens on the beds during the COVID-19 quarantine. -She knew the 2 housekeepers and the Maintenance Director did not go to the third floor during the COVID-19 quarantine. -She did not follow-up on the medication aide (MA) in regards to hospital discharge, medications orders or monthly reviews of the eMAR for holes or missed medications. A second interview on 09/21/20 at 10:32am with the Administrator revealed: -She was responsible for the day to day operations of the facility. -She had stand-up meetings daily in her office with department heads. -She had huddle meetings with direct care staff and MAs after the medication pass and breakfast each day. -Everyone was responsible for housekeeping. -The third floor was their independent floor. -The residents on the third floor wanted to clean for themselves. -The staff on third floor did not expect residents to	D980		

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D980	Continued From page 214	D980		

clean toilets.
-The facility always had enough staff on the third floor to assist with bathing and personal care needs.

Interview with a resident on 09/15/20 at 10:55am revealed:
-During the COVID-19 pandemic staff would not come in the room to assist with personal care, bathing or changing gowns.
-"Staff was rude to me when I ask for help."
-"The Administrator would not talk to me."

Telephone interview with the same resident's Power of Attorney (POA) on 09/18/20 at 10:05am revealed:
-The POA tried calling the Administrator multiple times, but the Administrator would not talk to her.
-She left messages with the Administrator but never received any calls back.
-The treatment her family member received from their staff was unacceptable and cruel.

Telephone interview with another resident's friend on 09/17/20 at 11:30am revealed:
-The resident told him she requested to go the hospital.
-The Administrator came to the resident's room to look at her, the Administrator told the resident she did not need to go the hospital.
-He was not sure if the Administrator was a medical provider or a nurse to make the call of not sending a resident out to the ER.
-The resident was sick for over a week and the facility would not send her out.

Telephone interview with a third resident's family member on 09/17/20 at 9:10am revealed:
-She was not made aware of the bruising on the resident's head, bruising to the right hip with a

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D980	Continued From page 215 skin tear, or the skin tear and bruising to the right shoulder. - "To have bruising on her head, she had to fall." Telephone interview with the facility's contracted pharmacist on 09/25/20 at 4:10pm revealed: -The pharmacy had not been able to get in touch with anyone at the facility for months. -Phone calls were not answered or the phone calls were dropped. -On 06/29/20 the pharmacy requested assistance in getting in touch with the facility. The current phone system was not usable. -The pharmacy faxed the facility 4 times to alert them to this request with no response from the facility. -The pharmacy then sent a copy of the request, to find a better way to communicate with the facility, in the tote with the medications the driver delivered to the facility. -The Administrator repeated the same phone number the pharmacy had been using and her email address. -The pharmacy had sent emails to the email address she provided and they had gone unanswered. -The phone calls were still unanswered, so the pharmacy did not attempt to contact the facility any longer. Interview with Resident #2's home health (HH) nurse on 09/16/20 revealed: -The facility's procedure to send a resident out to the hospital was the HH agency must speak to the Administrator prior to calling the primary care provider (PCP) regarding resident care and treatment. -The Administrator called the corporate office and spoke to the Chief Operations Officer (COO) before HH could contact the PCP.	D980		

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D980	Continued From page 216 -The Administrator was present when HH PT called and reported a resident's fall and bruises to the PCP. -The PCP wanted another resident sent out to the ED for evaluation of a head injury, and the Administrator would not send the resident out. Telephone interview with Resident #9's PCP on 09/21/20 at 9:10am revealed: - "I get more information from HH and PT then I do the facility staff." - "The facility is a mess." Interview with the Administrator on 09/21/20 at 2:25pm revealed: -She was unsure how a resident had sustained the bruising and skin tears documented on 09/07/20 that required x-rays to determine extent of the injuries. -She was unaware how often resident's care plans were to be updated for significant changes. -She was not aware of a resident's sacral wound nor had she seen any of the wounds. -"That is out of my scope of practice." Telephone interview with the Social Worker from the local hospital on 09/22/20 at 3:09pm revealed: -She had attempted to call the facility multiple times but the facility would not answer. -The Administrator had "hung up on the doctor" when he was trying to explain a resident's care and treatments. Non compliance continues: 1. Based on observations, interviews and record reviews, the facility failed to ensure the minimum number staff were always present to meet the needs of residents for 20 of 39 shifts sampled for	D980		

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D980	Continued From page 217 13 days between 09/02/20 and 09/14/20, which resulted in a lack of adequate staff required to provide personal care such as bathing, toileting, catheter care, skin care, dressing assistance, feeding assistance and grooming. [Refer to Tag 0188, 10A NCAC 13F .0604 Personal Care And Other Staffing (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 5 of 10 sampled residents (Resident #2, #9, #1, #7 and #17) including catheter care and personal care with showers and general hygiene (Resident #2); care for a strong smell of urine, a saturated incontinent brief, and multiple wounds (Resident #9); personal care and bathing (Resident #1); assistance with bathing, dressing, and incontinent care (Resident #7); and assistance with grooming, bathing, and dressing, as indicated in the Care Plan (Resident #17). [Refer toTag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A1 Violation)]. 3. Based on observations, interviews and record reviews the facility failed to ensure referral and followup to health care providers for 5 of 10 sampled residents (Resident #6, #9, #2 #10, and #3) regarding stomach pain, not feeling well, and not eating (Resident #6); a fall with injury to head and hip, multiple wounds and loss of weight (Resident #9); reporting of daily weights with parameters (Resident #2); medication refusals (Resident #10); and reporting of daily weights with parameters (Resident #3). [Refer toTag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to ensure	D980		

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D980	Continued From page 218	D980		

recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to practicing infection control procedures to reduce the risk of transmission and infection, including administration of medications following infection control measures, COVID-19 positive staff working with non-COVID-19 residents, screening of staff and essential visitors, practicing social distancing while in the smoking area, and staff wearing appropriate personal protective equipment (PPE) and practicing social distancing requirements. [Refer toTag 338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)].

5. Based on record reviews and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 4 of 9 sampled residents (Resident #2, #10, #3, and #4) related to not administering a diuretic and a scheduled pain medication, and not having available for administration medications for allergies, acid reflux, and a hand held inhaler for shortness of breath (Resident #2); not administering a blood pressure medication, a medication for nerve pain and a phosphate binder three times a week while at dialysis treatment (Resident #10); not having a nebulizer medication available for use for shortness of breath (Resident #3) and not administering a blood pressure medication (Resident #4). [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

6. Based on observations, interviews and record

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D980	Continued From page 219 reviews, the facility failed to ensure contact with the primary care provider (PCP) regarding changes in residents' condition related to the ability to self-administer medications, and resident non-compliance with the provider's orders for 3 of 5 sampled residents who self-administered medications (Residents #2, #12, and #1). [Refer to Tag 0376, 10A NCAC 13F .1005(b) Self-Administration Of Medications (Type B Violation)]. _____ The Administrator failed to to ensure the management, operations, and policies of the facility were implemented and rules were maintained for housekeeping and furnishing, other requirements, personal care and other staffing, resident assessment, personal care and supervision, health care, resident rights, medication administration, self administration of medications, and reporting of accidents and incidents. This failure resulted in serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on September 21, 2020 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 30, 2020.	D980		