Received Vir E-mail 9-15-2016 @ 5:02 pm

PRINTED: 08/23/2016 FORM APPROVED

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: R-C B. WING 08/10/2016 HAL013044 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {D 000} (D 000) Initial Comments Del attached Poc The Adult Care Licensure Section and the Cabarrus County Department of Social Services dated 9 15 16 la conducted a follow-up survey and complaint investigation on August 9, 2016 and August 10, 2016. The complaint investigation was initiated by the Cabarrus County Department of Social Services on August 5, 2016. (D 358) {D 358} 10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F 1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION. The Type A2 Violation was abated. Non-compliance continues. Based on observations, record reviews and interviews, the facility failed to assure medication was administered as ordered for 3 of 7 sampled residents (Resident #2, #4, and #6) with physician orders for Protonix (Resident #2), Aspirin, Simethicone Chew, Pravastatin, and Trazadone (Resident #6) and Coumadin (Resident #4). The findings are: A. Review of Resident #6's current FL2 dated 5/26/16 revealed: Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

STATE FORM

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: \_ R-C B. WING HAL013044 08/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {D 358} Continued From page 1 {D 358} -Diagnoses included chronic obstructive pulmonary disease, dyslipidemia, hypertension, circadian rhythm sleep disorder, osteoarthritis, See attached hypokalemia, chronic kidney disease (Stage 3), esophageal reflux, transient ischemic attack, POC date 0 9.15.16 lg depression with anxiety, chronic pain syndrome. -A physician's orders for an order for Aspirin 325 mg daily (a medication used to prevent recurrent heart attack or ischemic stroke). -A physician's order for Simethicone Chew 80 mg daily as needed (a medication used to used to reduce bloating, discomfort or pain caused by excessive gas). -A physician's order for Pravastatin 10 mg every night (a medication used to treat high cholesterol and triglyceride levels), Review of Resident #6's Resident Register revealed an admission date of 3/20/10. Review of Resident #6's record revealed a subsequent clarification order in Resident #6's record dated 4/28/16 for Trazodone 50 mg every night (a medication used to treat depression). Review of Resident #6's June 2016 Medication Administration Record (MAR) revealed: -An entry for aspirin 325 mg daily, scheduled for administration at 6:00 am. -An entry for Simethicone chew 80 mg daily as needed. -No documentation of administration of Simethicone Chew on MAR. -An entry for Pravastatin 10 mg every night scheduled for administration at 8:00 pm. -An entry for Trazodone 50 mg every night scheduled for administration at 8:00 pm. -Documentation of administration of the above medications as ordered 6/1/16 - 6/30/16.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING HAL013044 08/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {D 358} Continued From page 2 {D 358} Review of Resident #6's July 2016 MAR revealed: -An entry for aspirin 325 mg daily, scheduled for administration at 6:00 am. Dll attached Poc dated 9:15:16/19 -An entry for Simethicone chew 80 mg daily as needed. -An entry for Pravastatin 10 mg every night, scheduled for administration at 8:00 pm. -An entry for Trazodone 50 mg every night, scheduled for administration 8:00 pm. -Documentation of administration of the above medications as ordered 7/1/16 - 7/31/16. Review of Resident #6's August 2016 MAR revealed: -No entry for Aspirin, Simethicone Chew. Pravastatin, and the Trazodone on the MAR. -There were no documentation for administration of the Aspirin, Simethicone Chew, Pravastatin, or the Trazodone available for review from 8/1/16 -8/9/16. Interview on 8/10/16 at 11:19 am with Quality Control Aide (QCA) revealed: -The aspirin and the Trazodone had been discontinued starting in August. -She was unable to give a discontinue order for the aspirin or the Trazodone. -She was the second person that checked the MARs for accuracy and for new or discontinued orders after receiving them from the pharmacy. -She was not aware that the aspirin, Simethicone, Pravastatin or the Trazodone had been left off of the August 2016 MAR. Interview on 8/10/16 at 1:25 pm with the Administrator revealed: -She was not aware that the aspirin, Simethicone, Pravastatin, and the Trazodone had been left off of the MAR until it had been brought to her attention.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING HAL013044 08/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {D 358} Continued From page 3 {D 358} -There were no side effects or adverse reactions to Resident #6 not receiving the medications. -She had called the primary Doctor's office on 8/10/16 at 1:00 pm to get an order for the medications to be held from 8/1/16 - 8/9/16. Del attached POC dated 9:15:16 lg Interview on 8/10/16 at 2:15 with a second QCA revealed: -The MARs come in from the pharmacy and were checked by a QCA along with the MAR from the previous month. -The new MAR was checked for accuracy and new orders are verified and for orders that were left off. -If there was a clarification/discrepancy noted then the medication order is written on the MAR and the carbon copy was faxed to the pharmacy for revision or correction. -There was a second check done by another QCA or a Medication Aide once the corrected MAR is returned from the pharmacy. -If there was any other clarification needed then the doctor would be called. -The revisions and corrections were usually returned from the pharmacy within 24 hours after faxing the carbon copy to them. -She was not aware that the aspirin, Simethicone. Pravastatin or the Trazadone had been left off of the August 2016 MAR. Interview on 8/10/16 at 4:20 pm with the pharmacist revealed: -Resident #6's MAR's had been printed on 7/22/16 and there was a software setup issue which prevented the Aspirin, Simethicone. Pravastatin and the Trazadone from being entered on the MAR. -Any discrepancies that are noted by the facility are faxed to the pharmacy on the corrected carbon copy for clarification and a reprint of the

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A STATE OF THE PARTY OF THE PAR	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA		j 00)	10/2016
THE LIVIN	G CENTER OF CONCO	עאי	RREN C. COLEMA RD, NC 28027	AN BLVD.		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	MAR.  -The reprinted MAR delivery personnel the The carbon copy in the pharmacy.  -The clarification car faxed back to pharmand reprint.  Interview on 8/10/16 revealed:  -She has resided at the She did not feel she medications lately.  Interview on 8/10/16 #6's primary care phy Practical Nurse revealed:  -The resident had noted the The FL2 dated 5/26. Aspirin, Simethicone signed by their Nurse was not a note in Resident #6's record their another NP.  -She was unsure if the the resident #6's record their another NP.  -She was unsure if the the resident #6 had primary doctor.  Review of Resident #6 had primary doctor.  Review of Resident #7 revealed that there was 25 mg daily, Simethineeded, Pravastating Trazodone 50 mg every simple statement of the since Resident of the Since Resident of the Since Resident #6 had primary doctor.	would then be sent out by nat day.  and not been faxed back to  bon copy should have been acy by 8/1/16 for clarification  at 4:30 pm with Resident #6  the facility for 6 years.  Thad been getting all of her  at 5:00 pm with Resident ysician's office Licensed aled:  at been seen since 11/12/15.  If 6 containing the orders for and the Pravastatin was e Practitioner (NP), but there sident #6's record that the ident.  order dated 4/28/16 in for the Trazodone signed by the ere would be any issues if eccive those medications in the property of the property	{D 358}	bel attac dated 9.		
	Trazodone 50 mg eve	ery night. 16 at 11:19 am with a QCA,				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING: \_\_\_ COMPLETED R-C B. WING HAL013044 08/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {D 358} Continued From page 5 (D 358) -The medications on hand were checked and Aspirin and Trazodone were not present and were not listed on the August 2016 MAR. -A full pack of Simethicone Chews and the Pravastatin were in Resident #6's bin but not listed on August 2016 MAR. Del attached POC dated 9.15.16 lg B. Review of Resident #4's current FL 2 dated 5/31/16 revealed: -Diagnoses included non-operative hip fracture, history of deep vein thrombosis (DVT), chronic anti-coagulation, anemia, and hypertension. -An order for Coumadin (a blood thinner) 4.5 mg daily except Mondays and Fridays. -An order for Coumadin 3 mg on Mondays and Fridays. Review of Resident #4's record revealed: -A physician's order dated 6/24/16 for Coumadin 6mg today (6/24/16), and to start Coumadin 4.5 mg daily except 3mg on Monday, Wednesday, and Friday for an International Normalized Ratio (INR) level of 1.1. -INR values ranged from 1.1 to 3.4 in June 2016. 1.8 to 2.0 in July 2016, and was not due to be checked in August 2016 until 8/12/16. Review of Resident #4's June 2016 Medication Administration Record (MAR) revealed: -A pre-printed entry for Coumadin 3mg Monday and Friday and scheduled for 8:00 pm. There was a handwritten "discontinued 6/08/16" marking across the entry. Coumadin 3 mg was documented as administered on Wednesday, 6/01/16 and Friday, 6/03/16. No dose was documented as administered on Monday, 6/06/16 and no documentation for the reason it was not administered. -A second pre-printed entry for Coumadin 4.5 mg

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			A. BUILDING:		
		HAL013044	B. WNG		R-C
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			RD, NC 28027		
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{D 358}	Continued From page	6	{D 358}		
{D 358}	daily except Monday for 8:00 pm. There wa "discontinued 6/08/16 Coumadin 4.5 mg was administered on 6/01, 6/07/16.  -A handwritten entry to day and marked "hold was administered on 1-A handwritten entry for Monday, Wednesday and scheduled at 8:00 notation on 6/24/16. Odocumented as admin Wednesdays and Frid 6/10/16 to 6/30/16 and -A handwritten entry for only and scheduled or Coumadin 6 mg was administered on 6/24/-An entry for "Coumadin 6 mg was 6/09/16" and scheduled 4.5 mg was document except Mondays, Wednesd 6/09/16" and scheduled 4.5 mg was document except Mondays, Wednesd ordered from 6/11/16 to administered on Thurs 6/12/16. There was no	and Friday and scheduled as a handwritten " marking across the entry of secumented as 6/02, 6/04, 6/05, and of hold Coumadin for one of the original of hold Coumadin for one of the original of hold Coumadin for one of the original of hold coumading of the original origi	{D 358}	Del Ottached Poc dated 9.13	5.100
	on 6/09/16 or 6/12/16.	mg was not administered			
	days in June: 6/06, 6/0 no documentation for t not administeredCoumadin 3mg and C documented as administered as administered.	ministered on 3 scheduled 9 and 6/12/16. There was he reason the doses were oumadin 4.5 mg were stered on Wednesday, e of 7.5 mg at 8:00 pm.			
	Review of Resident #4 physician's order to ho	's record revealed no Id the Coumadin dose on			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C HAL013044 08/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) {D 358} Continued From page 7 (D 358) 6/08/16 and to change the Coumadin dose schedule. Review of Resident #4's July 2016 MAR revealed: All attached Poc dated 9:15:16 lg -An entry for Coumadin 3 mg on Monday, Wednesday and Friday and scheduled to be administered at 5:00 pm. -Coumadin 3 mg was documented as administered on Mondays, Wednesdays and Fridays from 7/01 to 7/29/16 except for on 7/13, 7/15 and 7/20/16. There was no documentation for the reason Coumadin 3 mg was not administered on those 3 days. -An entry for Coumadin 4.5 mg daily except Monday, Wednesday and Friday and scheduled to be administered at 5:00 pm. -Coumadin 4.5 mg was documented as administered daily except Mondays, Wednesdays and Fridays except for 7/10/16. There was no documentation for the reason Coumadin 4.5 mg was not administered on 7/10/16. Review of Resident #4's August 2016 MAR revealed: -An entry for Coumadin 3 mg on Monday, Wednesday and Friday and scheduled to be administered at 8:00 pm. -Coumadin 3 mg was documented as administered every Monday, Wednesday and Friday from 8/01 to 8/08/16. -An entry for Coumadin 4.5 mg daily except Monday, Wednesday and Friday and scheduled to be administered at 8:00 pm. -Coumadin 4.5 mg was documented as administered daily except Mondays, Wednesdays and Fridays from 8/01 to 8/08/16. Review of medications on hand on 8/10/16 at 3:00 pm for Resident #4 revealed: -Two Coumadin 4.5 mg cards dispensed on

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ R-C B. WING HAL013044 08/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) (D 358) Continued From page 8 (D 358) 7/28/16 and 8/03/16. -One Coumadin 3 mg card with doses left. Interview on 8/09/16 at 4:35 pm with a Medication Aide (MA) revealed: Del attached Poc dated 9:15:14:09 -The Quality Control Aides (QCAs) verified the MARs for accuracy when the new MARs came in. -The QCAs or the MAs were responsible to transcribing physician orders onto the MAR. -The MAs were to initial entries on the front of the MAR to document that a medication was administered. If a medication was not administered, documentation and the reason should be written on the back of the MAR. -Any errors or omissions should be reported to the QCA and the physician. Interview on 8/09/16 at 4:36 pm with a QCA revealed: -She verified resident MARs , "usually" with another QCA, when the next month's batch of MARs were received from the pharmacy. -The current MAR was compared to the new month's MAR for accuracy. -She was not aware there was no copy of the physician's order in Resident #4's record to hold the Coumadin dose on 6/08/16 and to change the Coumadin dose schedule. "She would call to obtain one from the Coumadin clinic." Interview on 8/10/16 at 11:30 am with Resident #4's physician's office nurse revealed: -The "Coumadin clinic" managed Coumadin dose orders for Resident #4 when INRs were obtained. -There was a physician's order dated 6/08/16 in their files to hold the Coumadin dosage on 6/08/16 and to start Coumadin 4.5 mg daily except 3mg on Monday, Wednesday, and Friday for an INR level of 3.4. -There was no record in the office files that the

STATEMENT	of Health Service Regul of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HA L013044	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C 08/10/2016
	ROVIDER OR SUPPLIER	160 WAR	DDRESS, CITY, STA REN C. COLEM. RD, NC 28027	AN BLVD.	
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{D 358}	facility had notified the Coumadin doses were to Resident #4 on 6/7/13, 7/15 or 7/20/16.  The physician experiments on 8/10/16 #4's Coumadin as ordered interview on 8/10/16.  There was no docut that the facility had a doses were missed Resident #4 on 6/01 7/15 or 7/20/16.  There was a physic their files to hold the 6/08/16 and to start except 3mg on Monfor an INR level of 3-They expected the Coumadin as ordered to contact them if clineeded.  They wanted Resided.  They wanted Resided.  The MAs were to read errors to the physical shaded in correct (July 2016, so had received incorrect (July 2016, so had received on 8/10/16 Executive Director—The MAs and the verify new MARs experies and some manual contents.	ne clinic or the physician that are missed or given incorrectly 01, 6/06, 6/09, 6/12, 7/10, 3. Cted the facility to administer and by the Coumadin clinic.  If at 11:50 am with Resident corpresentative revealed: mentation in the clinic files notified them that Coumadin or given incorrectly to 1, 6/06, 6/09, 6/12, 7/10, 7/13, clian's order dated 6/08/16 in a Coumadin dosage on Coumadin 4.5 mg daily iday, Wednesday, and Friday 3.4. facility to administer and arification of orders were dent #4's INR to be between the at 1:40 pm with another QCA export medication omissions and a title of the physician.  The Resident #4 had missed or coumadin doses in June or not notified the physician.  The at 2:20 pm with the revealed: QCAs were responsible to very month. The made lab and medication	{D 358}	per attached dated 9.15.10	Poc

	of Health Service Regu	lation (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O	CONSTRUCTION	(X3) DATE SUI	RVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ED
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{D 358}	Continued From pag	e 10	{D 358}			
		As were responsible for sician orders onto Resident's				
	Interview on 8/10/16	at 2:10 with Resident #4		All attached dated 9:15:16	POC	
		e staff ordered his labwork to		dated 9.15.16	lo	
ļ	-He was not aware w	when the labwork was showed up to draw it".			,	
	-He thought the facili	ity administered his				
	medication as ordere	ed by his physician. The had missed any doses of				
	Coumadin.					
		bleeding problems and				
	thought he was "pref -He did not have any					
	12/22/15 revealed:	nt #2's current FL2 dated				
		diabetes, anemia, anxiety,				
P.		ase, hypertension, renal able bowel syndrome.		,	ļ	
	-A physician's order	for Protonix 40 mg every 48				
		p inhibitor used to decrease produced in the stomach).				
	the amount of actu p	roduced in the storiach).				
		#2's June 2016 Medication			1	
	Administration Reco	rd (MAR) revealed: x 40 mg every other day and				
	scheduled for 8:00 a					
		itten markings that crossed				
	out the odd days on -Protonix 40 mg was					
		other day on even days as				
	ordered from 6/01 to					
	Review of Resident	#2's July 2016 MAR revealed:				
		x 40 mg every other day and				
	scheduled for 8:00 a					

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	EIED
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20,22			1	DEFICIENCY)		
{D 358}	Continued From page	e 11	{D 358}			
	-At the Protonix entry	there were handwritten		2		
	The state of the s	d out the even days of the				
		7/31/16, and also thru				
	7/29/16.			•		
	-Protonix 40 mg was			All actached dated 9.15.14	DAC	
		ther day on the odd days		pu maarice	100	
		except for 7/19, 7/27, and cumented as administered		Nated alaill	000	
	on 7/02 and 7/30/16.	surrented as doministered		valle 41514	199	
	-There was no docum	nentation on the front or				
	back of the MAR for t	the reason Protonix 40 mg				
	The Control of Control	l as ordered on 7/19, 7/27,				
	The State of the S	eason it was administered on				
	7/02 and 7/30/16.					
		2's August 2016 MAR on				
	8/09/16 at 2:00 pm re			1.10		
	scheduled for 8:00 ar	40 mg every other day and		2		
	-Protonix 40 mg was					
11	administered daily fro					
	-There were no mark	ings on the Protonix entry to			2	
		ster medications every other				
	day on odd days from	1 8/01 to 8/31/16.				
	Review of medication	ns on hand on 8/09/16 at				
	4:00 pm for Resident					
	-A Protonix 40 mg pu	nch card with labeled				
		ster every other day. A			11	
	Control of the Contro	1/16 for 15 tablets. There				
	were 13 tablets rema	- C				
		mined it Protonix 40 mg was every other day by reviewing				
	Resident #2's medica					
	Interview on 8/09/16	at 4:35 pm with a MA				
	revealed:					
		as used until empty, then a				
		was started. The facility did				
	not start a new card a	at the start of each month.				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **DENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ R-C B. WING HAL013044 08/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {D 358} Continued From page 12 (D 358) -Resident #2 was to receive Protonix 40 mg every other day. She did not know why "we are administering it daily". "The MAR was not marked off as usual" to guide in which day to administer it. She would mark it so staff administered the medication as ordered. -The Quality Control Aide (QCA) verified the All attached Poc dated MARs for accuracy when the new MARs came in. -The QCA or the MA were responsible for transcribing physician orders onto the MAR. -The MAs were to initial entries on the front of the 0.15.10 10 MAR to document that a medication was administered. Further review of Resident #2's August 2016 MAR on 8/10/16 at 8:30 am revealed there were handwritten markings at the Protonix entry that crossed out the even days of the MAR from 8/10 to 8/30/16. Interview on 8/09/16 at 4:36 pm with a QCA revealed: -She verified resident MARs ,"usually" with another QCA, when the next month's batch of MARs were received from the pharmacy. -The current MAR was compared to the new month's MAR for accuracy. Attempted telephone interview on 8/10/16 with Resident #2's physician or office nurse was unsuccessful. Interview on 8/10/16 at 10:00 am with Resident #2 revealed: -She thought the facility staff administered her medication as ordered by her physician. -She did not know how often she was ordered to take Protonix. Interview on 8/10/16 at 2:20 pm with the

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING HAL013044 08/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {D 358} Continued From page 13 (D 358) Executive Director revealed: -The MA and the QCA were responsible to verify new MARs every month. -The clinic provided Coumadin lab and medication orders for Resident #2. -The MA or the QCA were responsible for transcribing any physician orders onto residents' MARs. De attached POC dated 9-15-16 by {D 367} 10A NCAC 13F .1004(j) Medication (D 367) Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name: (2) name of the medication or treatment order: (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident: (6) date and time of administration: (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to assure the Medication Administration Records (MARs) were accurate, related to

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED R-C B. WING HAL013044 08/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) (D 367) Continued From page 14 {D 367} documentation of medications administered as needed (prn), for 2 of 7 sampled residents (Resident #5, and #6) with orders for hydrocodone/ APAP (#5), and Dilaudid (#6). The findings are: ple attached Poc dated 9.15.14 lg A. Review of Resident #6's current FL2 dated 05/26/16 revealed: -Diagnoses included chronic obstructive pulmonary disease, dyslipidemia, hypertension, circadian rhythm sleep disorder, osteoarthritis, hypokalemia, chronic kidney disease (Stage 3), esophageal reflux, transient ischemic attack, depression with anxiety, and chronic pain syndrome. -A physician's order for Dilaudid 2 mg every 6 hours as needed (pm). (Dilaudid is a narcotic medication used for chronic pain.) Review of Resident #6's Controlled Substance Sheet (CSS) revealed: -CSS dated 05/25/16 with a received count of 30 tablets to administer, dispensed on 05/25/16. -Nine tablets were documented as administered from 07/1/16 to 07/6/16 at 2:00 pm. -CSS dated 07/6/16 with a received count of 60 tablets to administer, dispensed on 07/6/16. -Twenty five tablets were documented as administered from 07/16/16 at 8:00 pm to 07/31/16 at 8:00 pm. -Thirty six doses of Dilaudid 2mg were documented as administered on the CSS from 07/01/16 to 07/31/16. Review of Resident #6's July 2016 Medication Administration Record (MAR) revealed: -An entry for 1 tablet administered from 07/01/16 to 07/06/16 on 07/03/16 at 2:00pm. -Five tablets documented as administered on the

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R-C B. WNG HAL013044 08/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {D 367} Continued From page 15 {D 367} July 2016 MAR from 7/06/16 to 7/31/16 at 8:00 -There was no entry for effectiveness of medication noted on MAR. Comparison of Resident #6's CSS for 05/25/16 and 07/06/16 to Resident #6's July 2016 MAR revealed: -Documentation for Dilaudid 2 mg on the MAR was blank on 30 of 36 occasions. -The medication was documented as administered on the CSS for the 36 occasions. -The reason the medication was administered, and the outcome/effectiveness of the medication was not documented for the 30 occasions. Examples of administration logged on Resident #6's CSS but not documented on the July 2016 MAR were as follows: -On 07/07/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 07/11/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 07/12/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 07/13/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. Review of Resident #6's CSS sheet revealed: -CSS dated 07/06/16 with a received count of 60 tablets to administer, dispensed 07/06/16. -Twelve tablets were documented as administered from 08/01/16 at 8:00 pm to 08/09/16 at 8:00 pm. Review of Resident #6's August 2016 MAR

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL013044 B. WNG 08/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {D 367} Continued From page 16 {D 367} revealed: -Four tablets were documented as administered on the August 2016 MAR from 08/01/16 to 08/09/16 at 8:00 pm. -All entries documented as given did not include time, reason or effectiveness of medication. Comparison of Resident #6's CSS for 07/06/16 to Resident #6's August 2016 MAR revealed: -Documentation for Dilaudid 2 mg on the MAR was blank on 8 of 12 occasions. -The medication was documented as administered on the CSS for the 12 occasions. -The reason the medication was administered, and the outcome/effectiveness of the medication was not documented for the 8 occasions. Examples of administration logged on Resident #6's CSS but not documented on the August 2016 MAR were as follows: -On 08/01/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 08/02/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR -On 08/03//16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 08/09/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. Interview with Resident #6 on 08/10/16 at 4:30 pm revealed that when she needed pain medicine, and she felt that the Medication Aides gave it to her every time. Interview with a day shift Medication Aide (MA) on 08/10/16/at 3:03 pm revealed:

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R-C HAL013044 B. WING 08/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. THE LIVING CENTER OF CONCORD CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {D 367} Continued From page 17 {D 367} -All "prn" medications were supposed to be documented on the front of the MAR, and on the back of the MAR for reason administered, MA staff should come back later and document on the back of the MAR if the medication was effective. -The MA staff documented removal of controlled substance from the locked drawer on the corresponding CSS. -She concentrated on making sure each Del Ottached POC dated 9:15:14 controlled substance was signed out on the CSS when it was removed form the lock drawer. -She used the CSS to determine if the proper time had passed before administering another dose of the medication. -She stated sometimes MAs may be interrupted during the documentation of the "prn" and overlook documenting on the MAR. -Each floor of the facility had a Quality Control Aide (QCA) that was responsible for monitoring medication orders and supervising MAs. -The QCA would be responsible for auditing for accuracy of the MARs compared to the CSS documentation. -She did not know if the QCA was conducting routine audits of the "prn" controlled substances. B. Review of Resident #5's current FL-2 dated 03/29/16 revealed: -Diagnoses included cardiomyopathy, atrial fibrillation, depression, urinary retention, and hypothyroidism. -Hydrocodone/acetaminophen 7.5-325 (a narcotic pain reliever used to treat moderate to severe pain) three times a day was ordered. Review of Resident #5's record revealed physician's orders dated 06/23/16 and 07/28/16 for hydrocodone/acetaminophen 10/325 one tablet every 6 hours as needed (prn) for pain.

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t to the desired to t	a representative for revealed: -Resident #5 was dishydrocodone/acetamback-up pharmacy or-Resident #5 was dishydrocodone/acetam-Resident #5 was dishydrocodone/acetam-Controlled Substance included with each disubstance for tracking controlled substance.  Review of Resident #hydrocodone/acetamperevealed documentation tablets from 07/01/16.  Review of Resident #hydrocodone/acetamperevealed documentation tablets on 07/31/16.  Review of Resident #Administration Recorderevealed: - Hydrocodone/acetamperevealed: - Hydrocodone/acetamperevealed: - Hydrocodone/acetamperevealed: - Hydrocodone/acetamperevealed: - Comparison of Resident #100cumented 42 times - Comparison of Resident #100cumented 42 times - Comparison of Resident Resident O7/31/16 to Resident Resident O7/31/16 to Resident Re	ninophen 10/325 through the on 06/24/16. spensed 30 ninophen 10/325 on 07/30/16. spensed 30 ninophen 10/325 on 08/05/16. ce Sheets (CSS) were spensing of a controlled go the administration of the dispension of the dispension of administration of 99 to 7/30/16.  5's inophen CSS for 06/24/16 ion of administration of 99 to 7/30/16.  5's Medication of 4  6's Medication of (MAR) for July 2016 ninophen 10/325 one tablet ded (prn) for pain was R.		Del attaches Por dated 9	15-16	

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	10/325 on the MAR	was blank on 61 of 103				
	occasions.	access en				
	-The medication was	CSS for the 61 occasions.				
	-The reason the med	lication was administered,				
	and the outcome/effe	ectiveness of the medication				
	was not documented	for the 61 occasions.				
1	Evamples of adminis					
	#5's CSS but not do	tration logged on Resident cumented on the July 2016				
	MAR were as follows	:				
	-On 07/02/16, CSS h	ad a dose signed out at 2:00				
	am, 8:40 am, 3:30 pm	n and 11:00 pm with one		Non atta	pland	
1	dose at 2:00 am docu	umented as administered on		All with	evilly 1	
	the MAR.			See attai	10161	
	am, 1:15 pm, and 7:1	ad a dose signed out at 4:30		rol author	10.10	
	documented as admir	istered on the MAD			95	7
	-On 07/19/16, CSS ha	ad a dose signed out at 1:00		IC III		' I
	am, 9:15 am, 3:15 pm	, and 10:30 pm with no				
	doses documented as	administered on the MAR				
	am, 12:10 pm, and 6:0	ad a dose signed out at 5:30				- 1
	documented as admir	ou pri with no doses distered on the MAR.				-
1	Review of Resident #8	S'e				
		nophen CSS for 07/30/16				1
1	and 08/05/16 revealed	32 tablets were signed out			1	
f	rom 08/01/16 to 08/10	0/16 at 1:30 pm.				
į F	Review of Resident #5	's MAR for August 2016				1
r	evealed;					
-	Hydrocodone/acetami	nophen 10/325 one tablet				
e	very 6 hours as need	ed (prn) for pain was				
-/	anscribed on the MA! Administration of "prn'	Κ.				
h	ydrocodone/acetamin	ophen 10/325 was				
d	ocumented 10 times f	rom 08/01/16 to 08/10/16.				
		nt #5's CSS for 07/30/16				
of Haalth	, and the state of	10 3 000 101 07/30/16				- 1

Division	n of Health Service Regi	ulation			FOR	MAPPROVED
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	and 08/05/16 to Resider revealed: -Documentation for hy 10/325 on the MAR we occasionsThe medication was administered on the Co-The reason the medicand the outcome/effect was not documented in the control of the c	dent #5's August 2016 MAR  ydrocodone/acetaminophen ras blank on 22 of 32  documented as CSS for the 22 occasions. cation was administered, ctiveness of the medication for the 22 occasions.  ration recorded on Resident umented on the August llows: d a dose signed out at 2:00 and 11:00 pm with no administered on the MAR. d a dose signed out at 5:00 pm with one dose istered on the MAR. d a dose signed out at 5:40 pm with no doses istered on the MAR. d a dose signed out at 2:00 and 10:40 pm with one dministered on the MAR. t #5 on 08/10/16 at 1:35  ad pain medication ordered		All attached for dated 9.	15-16	
	every dayShe had not been out of Interview with a day shi 08/10/16/at 3:03 pm rev -All "prn" medications w	of her pain medication.  If Medication Aide (MA) on realed:  ere supposed to be				
- (	uocumented on the fron	t of the MAR, and on the				

Division	of Health Service Reg				FO	RM APPROVED
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{D 367}	Continued From page	21	{D 367}			
tt	back of the MAR for a staff should come back the back of the MAR in effective.  -The MA staff docume substance from the locorresponding CSSShe concentrated on controlled substance when it was removed -She used the CSS to time had passed befor dose of the medication -She stated sometime during the documentation overlook documenting -Each floor of the facility Aide (QCA) that was remedication orders and -The QCA would be reaccuracy of the MARs documentationShe did not know if the routine audits of the "profit of the "profit of the "profit of the substances that were remedication cart on the coshe always documents substance from the bub he corresponding CSS MAs were supposed to fall "prn" medications, frugs, on the front and MARs.	eason administered. MA ck later and document on f the medication was ented removal of controlled cked drawer on the  making sure each was signed out on the CSS form the lock drawer, determine if the proper re administering another re. s MAs may be interrupted fion of the "prn" and on the MAR, ty had a Quality Control responsible for monitoring supervising MAs, sponsible for auditing for compared to the CSS re QCA was conducting rn" controlled substances.  In shift MA on 08/10/16 at responding CSS, red popping a controlled ble pack immediately on including controlled back of the residents'  cumenting the "prn" on reto interruptions or		All attack Puc dated	red 9:15:14	

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	documented the cont CSS, otherwise the c end of shift for contro	rolled substance on the ount would not be right for lled substances.					
	at 2:20 pm and 4:05 pm and 4:05 pm.  -Documentation for mm residents "as needed notation for the admin administration, and effeach dose administer and the verify new MARs ever administration and dora-The facility had an infewer of 8/07/16) for administration that we substances.  -She expected MAs to medications as trained as she was not aware Quarter than the QCAs would be not a completeness.	redications administered to (prn)" should include instration, reason for fectiveness/outcome for ed. the QCAs' responsibility to by month. The in-services for medication cumentation. The service earlier this week documenting medication and have included controlled the documenting "prn"		All	Obtached dated 9-15	5.14	Lg
r	revealed: -MAs were supposed to	on 08/10/16 at 5:45 pm					
fi fi th	The MAs were expected or proper documentation. The MAs were expected or proper documentation and the MAR were expected by the MAR was a second or the month of the month of the month of the medications. The did not have a system of the master of the month of the mon	tem in place to audit "pro"					

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{D 367}	Continued From pa	ge 23	{D 367}			
	Interview with a sec	cond QCA on 08/10/16 at 5:50				
	pm revealed:					
	according to require	cumenting "prn" medications				
	-She had not audite	d residents' MARs compared				
	to the CSS for accur	racy of "prn" controlled				
	medications previou	isly.				
1	-She would start aud "prn" medications in	diting the administration of				
	pin medications in	the iditire.		ADD DATADI	11	J
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STATE FORM

The Living Center of Concord HAL-013-044 Plan of Correction DHSR Survey 08/10/2016

# 10 NCAC 13F .1004 (a) Medication Administration

- (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
- (1) Orders by a licensed prescribing practitioner which are maintained in the resident's record; and
- (2) Rules in this section and the facilities policies and procedures

#### Plan of Correction

The ED/QC staff audited records to assure ensure residents were receiving medications as ordered.

08/11/2016

Staff retrained on proper medication administration per physician orders and Procedure to follow when residents refuse medications/orders. ongoing

08/11/2016 &

QC Staff/ SIC's were assigned the role of checking in all orders, documenting contact with physician and ensuring proper implementation of order.

08/11/2016

### Monitoring System

Executive Director/Quality Assurance Staff will randomly audit Medication administration records weekly x 4 weeks then monthly thereafter, to assure that medications are given per physician orders.

08/11/2016

Implementation of daily orders notebook that is reviewed by the QC to ensure that any orders received are clarified, implemented and documented on the MAR to ensure proper administration.

08/11/2016

Any staff found not following procedures will receive disciplinary action to include retraining, write up, and/or termination.

08/11/2016

The Living Center of Concord HAL-013-044 Plan of Correction DHSR Survey 08/10/2016

10NCAC 13F. 1004(j)

(j) The resident's MAR shall be accurate and include the following: (l) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission medications or treatments and the reason for the omission, including refusals; and, (8) the name or initials of the person administering the medication or treatment If initials are used, a signature equivalent to those initials is to be documented and maintained with the MAR.

### Plan of Correction

Implementation of daily orders notebook that is reviewed by the QC to ensure that any orders received are clarified, implemented and documented on the MAR to ensure proper administration

08/11/2016

Staff retrained on proper medication administration and MAR requirements.

08/11/2016

QC/ED reviewed MAR's to assure that they reflect resident's orders as prescribed by the physician.

08/11/2016

## Monitoring System

Executive Director/Quality Assurance Staff will randomly audit Medication administration records weekly x 4 weeks then monthly thereafter, to assure that medications are given and documented on the MAR per physician orders.

08/11/2016

Implementation of daily orders notebook that is reviewed by the QC to ensure that any orders received are clarified, implemented and documented on the MAR to ensure proper administration.

08/11/2016

Any staff found not following procedures will receive disciplinary action to include retraining, write up, and/or termination.

08/11/2016

Signature / Executive Director

Date