STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey and complaint investigations on April 19-21, 2017. The complaints were initiated by the Mecklenburg County Department of Social Services on March 03, 2017, March 09, 2017, April 12, 2017, and April 17, 2017.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 3 of 7 sampled staff (Staff D, A and E) were tested upon employment for Tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: A. Review of Staff D's personnel file revealed: -Staff D was hired on 01/06/17 as the Memory Care Coordinator (MCC). -There was no documentation of a TB skin test prior to or upon hire.	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

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D 131	Continued From page 1 -There was no further documentation of two TB skin tests. Attempted telephone interview on 04/21/17 at 12:15 pm with Staff D was unsuccessful. Refer to interview on 04/21/17 at 9:35 am with the Business Office Manager. Refer to interview on 04/21/17 at 10:20 am with the Staffing Coordinator. Refer to interview on 04/21/17 at 2:10 pm with the Resident Care Coordinator. Refer to interview on 04/21/17 at 2:20 pm with the Executive Director. B. Review of Staff A's personnel file revealed: -A hire date of 02/14/17 as a Personal Care Aide (PCA). -There was documentation of a negative TB test on 08/31/16. -Staff A had no other documentation of having a second TB skin test prior to or upon hire. -There was no documentation of two TB skin tests within 12 months of each other. Interview on 04/21/17 at 10:30 am with Staff A revealed: -She had a TB skin test prior to starting work at the facility in February 2016, and gave the hiring staff the documentation from her former employer. -She did not know it was required to have a 2 step TB skin testing. Refer to interview on 04/21/17 at 9:35 am with the Business Office Manager.	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

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D 131	Continued From page 2	D 131		

Refer to interview on 04/21/17 at 10:20 am with the Staffing Coordinator.

Refer to interview on 04/21/17 at 2:10 pm with the Resident Care Coordinator.

Refer to interview on 04/21/17 at 2:20 pm with the Executive Director.

C. Review of Staff E's personnel file revealed:
-Staff E was hired on 01/13/17 as a PCA.
-There was documentation of a negative TB test on 04/08/16.
-Staff E had no other documentation of having a second TB skin test prior to or upon hire.
-There was no documentation of two TB skin tests within 12 months of each other.

Interview on 04/21/17 at 11:15 am with Staff E revealed:
-She had a TB skin test prior to starting work at the facility in January 2017.
-She was not aware it was required to have a 2 step TB skin testing.
-She had not received TB skin testing since starting work at this facility.

Telephone interview on 04/21/17 at 11:15 am with Staff E's former employer revealed that Staff E had only 1 TB skin test documentation on file, and it was negative on 04/08/16.

Refer to interview on 04/21/17 at 9:35 am with the Business Office Manager.

Refer to interview on 04/21/17 at 10:20 am with the Staffing Coordinator.

Refer to interview on 04/21/17 at 2:10 pm with the Resident Care Coordinator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 131	Continued From page 3 Refer to interview on 04/21/17 at 2:20 pm with the Executive Director. Interview on 04/21/17 at 9:35 am with the Business Office Manager (BOM) revealed: -She put staffing records together that were sent to her, including the pre-employment information collected by the Staffing Coordinator which was to include any certifications, credentials, and TB skin testing done prior to hire. -She was not aware who gave the staff the TB skin testing if the 2 step was not completed prior to hire. -The nursing department also kept staffing records, so she was not concerned that the TB testing results were not in all the personnel files in her office, including Staff A, D and E. -It was the BOM reasonability to make sure the personnel files were complete. Interview on 04/21/17 at 10:20 am with the Staffing Coordinator revealed: -She had worked at the facility since August 2015. -She asked all new hires for any certifications, credentials, and TB skin testing done prior to hire, and forwarded those with the pre-employment packet to the BOM. -She was not aware who gave the staff the TB skin testing if the 2 step was not completed prior to hire. Interview on 04/21/17 at 2:10 pm with the Resident Care Coordinator revealed: -The BOM was in charge of making sure the TB skin testing for staff was done. -"I think the staff should have TB testing completed before they were hired". -She was not aware that Staff A, D and E did not have a completed 2 step TB skin testing.	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 131	Continued From page 4 Interview on 04/21/17 at 2:20 pm with the Executive Director revealed: -The BOM was in charge of making sure the TB skin testing for staff was completed as required. -She was not aware the TB skin testing was not completed as required.	D 131		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 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: Based on observations, interviews and record reviews the facility failed to ensure personal care to residents according to the resident's care plans for 3 of 7 sampled residents, two that required assistance with transfers (Resident #3 and #7), and one resident requiring limited assistance with toileting (#12). The findings are: Observations during the initial tour of the facility on 04/19/17 from 9:45 am to 11:30 am revealed: -During the initial tour, a call bell was activated in Room 200 (special care unit) and staff responded to the call bell within 3 minutes. -At 10:40 am, a call bell was activated in Room 300 . Staff responded to the call bell at 10:43 am	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 269	Continued From page 5	D 269		

(within 3 minutes).
-The Medication Aide administered an "as needed" pain medication to a resident in Room 306 after answering a call bell activation at 10:45 am.
-A resident in Room 311 was being assisted by a personal care aide with dressing and grooming at 11:30 am.

Review of the facility's Call Bell Reconciliation Report by 24 hour periods, for call bell activation and response time before call bell reset, revealed:
-On 03/05/17, there were 9 call bell activations with more than 20 minutes before reset (census was 95 residents).
-On 03/06/17, there were 6 call bell activations with more than 20 minutes before reset (census was 95 residents).
-On 03/07/17, there were 4 call bell activations with more than 20 minutes before reset (census was 95 residents).

A. Review of Resident #3's current FL-2 dated 07/25/16 revealed diagnoses of anxiety, arthritis, cerebral vascular accident, diverticulosis, hypercalcemia, osteopenia, insomnia, seizure disorder, hemorrhoids, and obesity.

Review of Resident #3's Resident Register revealed an admission date of 07/30/13 and a resident initiated discharge date of 04/12/17.

Review of Resident #3's record revealed:
-Resident #3's Care Plan dated 07/25/16 revealed documentation the resident required "total dependence" with toileting and transfers.
-Resident #3's current Licensed Health Professional Support (LHPS) dated 11/21/16 included instructions to "Assist with all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 269	Continued From page 6	D 269		

transferring and be sure to use at least 2 persons for all."

Observation on 04/12/17 at 9:55 am of Resident #3 during a visit by the county Adult Home Specialist revealed Resident #3 had an electronic call bell pendant on a lanyard around her neck.

Interview on 04/12/17 at 9:55 am with Resident #3 revealed she did not know what the call bell pendant was used for.

Resident #3 was not available for interview on 04/19/17 - 04/21/17.

Interview with Resident #3's responsible party on 04/20/17 at 6:00 pm revealed:
-He lived out of state, and visited the resident when he was able.
-He had observed Resident #3 have a bowel movement in her clothing while waiting for staff assistance on one of his visits in February 2017.
-He had observed facility staff take 20-30 minutes to respond to call bells, during one of his recent visits.
-He had observed facility staff attempt to transfer Resident #3 using only 1 person, during his visit to the facility in March.
-He had been told by Hospice nurses that Resident #3 always needed 2-person assistance with transfers.
-He had spoken with the Resident Care Coordinator (RCC) about his concern of observing Resident #3 being transferred by 1 person.
-The RCC told him staff always used 2-person assists for Resident #3.

Interview on 04/20/17 at 10:45 am with a person care aide (PCA) revealed she had recently had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 269	Continued From page 7	D 269		

specific training on the use of Hoyer lift by the durable medical equipment supplier for the lift and the recommendation for 2 person operation.

Interview on 04/20/17 at 1:45 pm with a second PCA revealed she had recently had specific training on the use of Hoyer lift by the durable medical equipment supplier for the lift and the recommendation for 2 person operation.

Interview on 04/20/17 at 3:30 pm with the Resident Care Coordinator (RCC) revealed staff had recently been inserviced for proper use of the mechanical lift (2 person).

Refer to confidential interview with a facility staff member.

Refer to interview on 04/20/17 at 3:30 pm with the RCC.

Refer to interview on 04/21/17 at 5:00 pm with the RCC and Executive Director.

B. Review of Resident #7's current FL-2 dated 07/06/16 revealed diagnoses of congestive heart failure, diabetes mellitus, hypertension, hyperlipidemia, vitamin D deficiency, chronic kidney disease, obesity, aortic valve replacement, overactive bladder, benign prostatic hyperplasia, history of basal cell sarcoma, osteoarthritis, and peripheral neuropathy.

Review of Resident #7's Resident Register revealed an admission date of 07/06/16.

Review of Resident #7's record revealed:
-Resident #7's care plan dated 08/02/16 revealed documentation the resident required "total dependence" with transfers and bathing, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 269	Continued From page 8	D 269		

required "extensive assistance" with toileting and dressing.
-Resident #7's Licensed Health Professional Support (LHPS) dated 11/22/16 included instructions "When transferring with a mechanical lift always use 2 people and communicate with the resident what you plan on doing before you start."

Interview with Resident #7 on 04/19/17 at 11:00 am revealed:
- Resident #7 had an electronic call bell pendant that he wore on a lanyard around his neck and he would press the button to request staff assistance.
- Resident #7 had sometimes waited 30 minutes for staff to respond after pressing the call bell pendant.
- Resident #7 had urinated on his clothing and wheelchair occasionally while waiting for staff to respond to the call bell.
- Resident #7 required mechanical lift assistance with all transfers.
- On occasion, only 1 facility staff would assist with transferring him using the mechanical lift.
-He had read the manuafacturer's instruction manual for the mechanical lift, and obtained a copy of the facility's policy for staff using a Hoyer lift.
- Resident #7 was aware that the mechanical lift facility policy and the manufacturer's user manual instructions stated 2 people were necessary for safe use of the mechanical lift.
-Resident #7 had told the care staff that the manufacturer of the lift recommended 2 person operation of the lift.

Confidential interview with a facility staff member revealed:
-She was aware that some residents required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 9	D 269		

2-person mechanical lift assistance.
-She had observed residents being transferred using a Hoyer lift by only 1 facility staff person, on more than one occasion.
-She had not reported staff operating the mechanical lift with only one person to administration.

Interview on 04/20/17 at 10:45 am with a person care aide (PCA) revealed she had recently had specific training on the use of Hoyer lift by the durable medical equipment supplier for the lift and the recommendation for 2 person operation.

Interview on 04/20/17 at 1:45 pm with a second PCA revealed she had recently had specific training on the use of the mechanical lift by the durable medical equipment supplier for the lift and the recommendation for 2 person operation.

Interview on 04/20/17 at 3:30 pm with the Resident Care Coordinator (RCC) revealed staff had recently been inserviced for proper use of the mechanical lift (2 person).

Refer to confidential interview with a facility staff member.

Refer to interview on 04/20/17 at 3:30 pm with the RCC.

Refer to interview on 04/21/17 at 5:00 pm on with the RCC and Executive Director..

C. Review of Resident #12's current FL-2 dated 07/22/16 revealed diagnoses of Alzheimer's dementia, hypertension, and essential tremors.

Review of Resident #12's Resident Register revealed an admission date of 07/13/15.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 10 Review of Resident #12's record revealed: -Resident #12's Care Plan dated 07/13/16 revealed documentation the resident required limited assistance with toileting. Observation with Resident #12 on 04/19/17 at 11:05 am revealed Resident #12 had an electronic call bell pendant on a lanyard around her neck. Based on record review and observation on 04/19/17, Resident #12 was unable to provide reliable information. Interview with a family member for Resident #12 on 04/19/17 at 11:10 am revealed: -Facility staff could not be found when using the call bell pendant on behalf of Resident #12. -Facility staff had answered the call bell after 20-30 minutes of waiting on at least two occasions in the past few months. -He had observed staff would initially answer the call bell by coming to the resident room to reset the call bell pendant and would leave without assisting the resident. -Staff would say they would be back later to assist the resident. -Resident #12 had waited up to 30 additional minutes for facility staff to return to provide care after facility staff had reset the call bell pendent. -The family member had not reported the incidents to facility management. -There had been occasions when Resident #12 had urinated on her clothes while waiting for facility staff assistance. This occurred often, at least 3 times per week. Refer to confidential interview with a facility staff member.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 11 Refer to interview on 04/20/17 at 3:30 pm with the RCC. Refer to interview on 04/21/17 at 5:00 pm on with the RCC and Executive Director.. Confidential interview with a facility staff member on revealed: -She had observed resident call bells go unanswered for up to 30 minutes. -Facility staff would often reset resident call bells and return at a later time to perform the necessary personal care task with the resident. -She had observed residents waiting for personal care assistance due to the facility having limited staffing to care for higher need residents. Interview on 04/20/17 at 3:30 pm with the RCC revealed: -Staff had been repeatedly instructed that call bells were to be answered promptly. -The RCC reviewed the response time for call bells daily and instructed staff that all calls should be answered in no longer than 15 minutes. -She was not aware that staff were resetting the call bells and telling the residents that they would return to provide personal care. Interview on 04/21/17 at 5:00 pm on with the RCC and Executive Director revealed: -The facility had experienced a large turnover of personal care aides within the last 3 months. -The facility call bell procedures had been reviewed when the new personal care aides were hired. -No staff had told the RCC or Executive Director they were currently having trouble providing personal care in a timely manner.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 12	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: Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 7 (#4 and #5) sampled residents. (Escitalopram and diltiazem for Resident #4, and metoprolol for Resident #5.) The findings are: A. Review of Resident #4's current FL-2 dated 06/13/16 revealed: -Diagnoses included diabetes and hypertension. -Medication orders for 6 oral medications included diltiazem extended release (ER) 120mg daily and escitalopram 20mg daily. (Diltiazem is used for irregular heartbeat and hypertension and escitalopram is used for depression and anxiety.) Review of Resident #4's Medication Administration Record (MAR) for April 2017 revealed: -An entry for diltiazem 120mg ER, 1 capsule every day, with a scheduled administration time of	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 13	D 358		

8am.
-The diltiazem 120mg ER had been initialed as administered (documented as administered) from 04/1/17 through 04/18/17 with the exception of 04/12/17 and 04/13/17 circled as not given.
-The exception sheet of the MAR for April 2017 noted on 04/12/17 and 04/13/17 diltiazem 120mg ER was not available, "ordered from pharmacy, or family, (named provider), or other provider notified."

Review of Resident #4's record revealed:
-No order for routine blood pressure checks.
-Staff obtained a blood pressure reading for Resident #4 of 142/60 on 4/21/17 at 12:10pm.

Review of Resident #4's Medication Administration Record (MAR) for April 2017 revealed:
-An entry for escitalopram 20mg, 1 tablet every day, with a scheduled administration time of 8am.
-The escitalopram 20mg had been documented as administered from 04/01/17 through 04/11/17, and 04/17/17.
-On 04/12/17 the slot for initials of administration of escitalopram was blank.
-On 04/13/17 through 04/16/17, and 04/18/17 the Medication Aides (MA) initials were circled which indicated the escitalopram was not administered on those days.
-The exception sheet of the MAR for April 2017 noted on 04/13/17 through 04/16/17 and 04/18/17, the escitalopram omissions due to "medication unavailable and ordered from pharmacy, or family (named provider), or other provider notified."

Review of Resident #4's MAR for March 2017 revealed both the diltiazem 120mg ER and escitalopram 20mg were documented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 14	D 358		

administered every day from 03/01/17 through 03/31/17.

Observation of Resident #4's medications on hand at 3:44pm on 04/20/17 revealed:
-Two bottles of 30 tablets of escitalopram 20mg tablets, labeled 1 tablet daily, with a dispense date of 04/18/17, the same prescription number on both bottles, and the number of tablets dispensed was 60.
-Only 1 of the bottles of escitalopram 20mg was opened, and the open bottle contained 29 tablets.

Observation of Resident #4's medications on hand at 3:45pm on 04/20/17 revealed:
-One bottle of diltiazem ER 120mg capsules, labeled 1 capsule daily, with a dispense date of 04/12/17 and 90 capsules dispensed.
-Eighty-three capsules remained in the opened bottle of diltiazem ER 120mg.
-Resident #4's medications had been dispensed from a local chain pharmacy, not the facility's pharmacy provider.

Interview with Resident #4 on 04/20/17 at 2:35 pm revealed:
-Resident #4's family member obtained her medications from a local chain pharmacy.
-She did not ever recall running out of her diltiazem.
-She ran out of her escitalopram recently, "for 3 or 4 days."
-While she was out of her escitalopram, she "did not have any energy," but other than that, had no adverse effects from running out of her medication.
-Resident #4 thought her family member brought her medication into the facility, gave them to a MA, and they were lost.
-"They never did find that medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 15	D 358		

(escitalopram.)"
-The family member had to pay to replace the escitalopram, but the facility was "going to refund or credit the cost."

Interview with the family member on 04/21/17 at 8:41 am revealed:
-The facility staff called in refills for Resident #4's medications to a local chain pharmacy.
-The chain pharmacy refilled the medications and "sent me a text indicating they were ready for pick up."
-The facility "lost" Resident #4's prior refill of escitalopram, "I gave 3 boxes of 30 tablets to the 3rd floor MA around 03/02/17."
-"The Medication Aide I gave them to was new (newly hired), I did not know her name."
-"I had to get a new script from [Resident #4's] doctor to refill her escitalopram on 04/18/17."
-The refill was for 60 tablets of escitalopram, and "I had to pay $138.00 out of pocket because I had just gotten a 90 day supply on 03/02/17."
-"They are supposed to issue as credit for that amount on [Resident #4's] next bill."
-"I refilled the escitalopram as soon as staff told me she was out."
-"The Resident Care Coordinator (RCC) told me she did not miss any doses of escitalopram, because staff had borrowed them from other residents."
-"Staff (unspecified) called me to refill the diltiazem, but it was on a weekend, and I could not get in touch with the physician to request a refill."
-The RCC had to get in touch with the doctor to obtain a new prescription refill for the diltiazem.
-Staff usually called me ahead of time to order Resident #4's medications, but "I'm not sure how many days ahead they call."
-The family member was not aware of any side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 358	Continued From page 16 effects from missing doses of the diltiazem or escitalopram. Interview with the RCC on 04/21/17 at 10:15 am revealed: -She believed Resident #4's family member came in around 3/7/17 and left a 90 day supply of escitalopram 20mg with the marketing director of the facility at the front desk. -That marketing director had not worked at the facility for at least 2 weeks. -The escitalopram was packaged in 3 packs of 30 tablets each. -At some point, 2 of the 3 packs"went missing, and staff searched for them." -The family member was contacted, and he obtained a refill of 60 tablets from a local chain pharmacy. -"The cost of the escitalopram was around $138.00 and we (facility) agreed to reimburse him for the cost." -With the diltiazem, there were no refills remaining, and the family member could not get in touch with the physician. -"I faxed the physician and got refills for the diltiazem for (Resident #4.)" -The family member then picked up the diltiazem from a local chain pharmacy. -"I never told the family member (Resident #4) hadn't missed any escitalopram." -"I told the family member staff may have borrowed some escitalopram for (Resident #4)." Interview with a MA on 04/20/17 at 4:40 pm revealed: -The MAs do not order Resident #4's medications. -She did not recall the resident ever running out of any of her medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 358	Continued From page 17 Interview with a second MA on 04/21/17 at 8:15 am revealed: -She did not recall Resident #4 ever running out of her diltiazem, but "she ran out of her escitalopram a few days." -The MA was not sure what happened with the escitalopram. - "We (MAs) call in Resident #4's medication refills to (named chain) pharmacy, and the family member picks them up. -"I usually try to call when there are about 10 tablets in the bottle." Attempted interview on 04/21/17 at 8:40 am with Resident #4's physician was unsuccessful. Review of the facility's policy on outside pharmacy medications revealed: -In the event the resident/responsible party selects to use a pharmacy other than the community pharmacy, they must provide medications on a timely basis and ensure resident always has medications available for administration. -In the event a medication has run out and the family has not delivered the medication, a seven day supply will be ordered from the backup pharmacy (named contract pharmacy) and the amount will be billed to the resident accordingly. -The RCC or Executive Director will be notified if medications are not received from the backup pharmacy by the following delivery day. B. Review of Resident #5's current FL-2 dated 02/15/17 revealed: -Diagnoses included dementia, diabetes mellitus, and hypertension (high blood pressure). -An order for metoprolol tartrate 25 mg (used to treat high blood pressure) one every 12 hours.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 358	Continued From page 18 Review of Resident #5 record revealed: -No subsequent physician's order for Resident #5's metoprolol tartrate 25 mg from 02/15/17 to 04/19/17. -A signed physician's order dated 04/19/17 with administration times for metoprolol tartrate 25 mg listed at 9:00 am and 6:00 pm. Review of Resident #5's electronic medication administration record (eMAR) for February 2017 revealed: -An entry for metoprolol tartrate 25 mg scheduled for administration at 9:00 am and 9:00 pm, and documented as administered at 9:00 am and 9:00 pm on 02/18/17, 02/19/17, 02/20/17, and 02/21/17. -An entry for metoprolol tartrate 25 mg scheduled for administration at 9:00 am and 6:00 pm, and documented as administered at 9:00 am and 6:00 pm from 02/22/17 to 02/28/17. Review of Resident #5's record revealed a signed physician's order dated 04/19/17 with administration times for metoprolol tartrate 25 mg listed at 9:00 am and 6:00 pm. Review of Resident #5's eMARs for March 2017 and April 2017 revealed: -An entry for metoprolol tartrate 25 mg scheduled for administration at 9:00 am and 6:00 pm, and documented as administered at 9:00 am and 6:00 pm from 03/01/17 to 04/18/17. Telephone interview on 04/21/17 at 8:45 am with a representative for the contract pharmacy provider revealed: -The pharmacy staff enter the orders in the eMAR system from orders faxed from the facility. -The pharmacy staff entered the original order for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 19	D 358		

metoprolol tartrate 25 mg one every 12 hours on 02/17/17 from the faxed FL-2 dated 02/15/17.
-The pharmacy scheduled the metoprolol for 9:00 am and 9:00 pm (12 hours apart) when it was entered by the pharmacy staff.
-The pharmacy had received no documentation for a physician's order to change the scheduled time of administration for Resident #5's metoprolol tartrate 25 mg from 9:00 pm to 6:00 pm from the facility.
-The facility had the ability to change times of administration at the facility level.
-The metoprolol tartrate 25 mg administration time of 9:00 pm was changed, and 6:00 pm added, by a staff member at the facility.

Interview on 04/21/17 at 3:15 pm with the Resident Care Coordinator (RCC) revealed:
-She was not aware Resident #5's metoprolol tartrate 25 mg was not being administered every 12 hours as ordered on FL-2 dated 02/15/17.
-The DON, RCC, and nursing staff were responsible to assure medication orders were correctly reflected on the eMARs.
-The RCC had not done record audits for medications compared to the eMARS in the last 3 months due the time constraints of dealing with staff turnover and replacement.
-Review of the electronic time stamp for order changes made to the eMAR revealed a staff member, no longer employed at the facility, made the change to the administration time for Resident #5's metoprolol from 9:00 pm to 6:00 pm.
-She could not find documentation for a physician's order for changing the 9:00 pm time to 6:00 pm or notes from the former staff member for approval of the change.
-She faxed notification of the change of meteprolol from 9:00 pm to 6:00 pm to Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 358	Continued From page 20 #5's primary care physician and requested Interview with the Executive Director on 04/21/17 at 4:00 pm revealed: -She had been Executive Director at the facility for about 3 months and had experienced a lot of staff turnover. -She was unaware of the discrepancies with the administration of medications for the residents. -It was the responsibility of the Resident Care Coordinator, Director of Nursing, and nursing staff to assure the administration of medications was in compliance.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure Medication Aides (MA) observed residents take their medications after administration for 1 of 1 resident (#14) observed during a breakfast meal observation and 1 of 7 (#4) sampled residents. The findings are:	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 366	Continued From page 21 A. Review of Resident #4's current FL-2 dated 6/13/16 revealed: -Diagnoses included diabetes and hypertension. -Medication orders for 6 oral medications. -The medications ordered included atenolol 25mg daily, diltiazem ER 120mg daily, aspirin 81mg on Monday, Wednesday, and Friday, escitalopram 20mg daily, Miralax 1 capful (17 grams) in 8oz of water, and simvastatin 10mg at bedtime. (Low dose aspirin is used to prevent blood clots, diltiazem and atenolol are used for irregular heartbeat and hypertension, escitalopram is used for depression and anxiety, simvastatin is used to lower cholesterol levels in the blood, and Miralax is a laxative.) Review of Resident #4's record revealed no physician's order to self-administer medications. Interview with Resident #4 on 4/20/17 at 2:35 pm revealed: -The MAs left her medications in a plastic cup on the table in the living area of her room. -Various MAs administered her medications that way. -Staff do not mix the Miralax with water, "I do that before I take it." -"I like to take my medications after I eat breakfast, and I eat breakfast in my room." -"I always take my medications." Interview with a MA on 4/20/17 at 3:44 pm revealed: -She does not observe Resident #4 take her morning medications. -She leaves them in a medication cup in the resident's room for Resident #4 to take at a later time. -She was trained by other MAs to administer Resident #4's medications in that manner.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 366	Continued From page 22 -She believed Resident #4 always took her medications. Interview with a second MA on 4/21/17 at 8:15 am revealed: -She always watched residents take their medications except for Resident #4. -Resident #4 liked to sleep late and will not take her medications early. -She had been taught to administer Resident #4's medications that way by other MAs. Interview with the Resident Care Coordinator on 4/21/17 at 10:15 am revealed she was not aware staff were leaving medications in Resident #4's room for her to take at a later time. Refer to review of the facility's Medication Aide Job Description. B. Review of Resident #14's current FL-2 dated 1/19/17 revealed: - Diagnoses included anemia, weakness, and anxiety disorder. -Medication orders for 15 oral medications. Review of updated medication orders dated 3/17/17 included: -Calcium 600mg plus vitamin D, 1 tablet daily. (Calcium with vitamin D is used for nutrition supplementation to prevent and treat osteoporosis.) -Diltiazem ER 180mg, 1 capsule daily. (Diltiazem is used to treat hypertension and irregular heart rhythm.) -Aspirin 81mg, 1 tablet daily. (Low dose aspirin is used to prevent blood clots.) -Ferrous sulfate 325mg, 1 tablet three times a day. (Ferrous sulfate is a supplement used to treat iron deficiency anemia.)	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 366	Continued From page 23 -Furosemide 40mg, 1 tablet twice daily. (Furosemide is used to treat hypertension, heart failure, and edema.) -Levothyroxine 100mcg, 1 tablet daily. (Levothyroxine is a hormone supplement used to treat hypothyroidism.) -Liothyronine 5mcg, 1 tablet daily. (Liothyrinone is a hormone supplement used to treat hypothyroidism.) -Myrbetriq 50mg, 1 tablet daily. (Myrbetriq is used to treat urinary incontinence and urgency.) -Preservision Areds 2, 1 capsule twice daily. (Preservision Areds 2 is a nutritional supplement used to support eye health.) -Warfarin 2mg, 1 tablet daily. (Warfarin is used to prevent blood clots.) -Omega 3 fish oil 1gm, 1 capsule twice daily. (Omega 3 fish oil is used as a nutritional supplement used to treat elevated blood lipids.) -Potassium chloride 20meq ER, 1 tablet daily. (Potassium chloride is a supplement used to prevent low blood potassium levels.) -Omeprazole 40mg, 1 tablet daily. (Omeprazole is used to treat gastric reflux.) -Simvastatin 20mg, 1 tablet daily. (Simvastatin is used to treat elevated cholesterol levels in the blood.) -Citalopram 20mg, 1 tablet daily. (Citalopram is used to treat anxiety and depression.) -Ten of the 15 oral medications were scheduled to be administered in the morning. Random observation on 4/20/17 at 8:25 am in the assisted living dining room revealed: -A Medication Aide (MA) gave a medication cup full of tablets and capsules to Resident #14 at tablet #8. -Resident #14 was seated at the table waiting for her breakfast. -The MA then walked away and greeted another	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 366	Continued From page 24	D 366		

resident at another tablet without watching Resident #14 take her medications.
-The MA then walked back to the medication cart on the other side of the room and prepared another resident's medications, took them to that resident, and observed him take the medications.
-The MA then walked back to the medication cart and prepared a third resident's medications, took them to that resident, and observed him take the medications.

Observation on 4/20/17 at 8:31 am revealed:
-Resident #14 took all the medications in the medication cup after two other residents medications had been prepared, administered, and observed taken.
-The MA did not observe Resident #14 take her medications at this time.

Interview on 4/20/17 at 3:44 pm with the MA who administered Resident #14's medications revealed:
-She doesn't always observe Resident #14 take her medications.
-She tried to keep and eye on Resident #14 to make sure she took her medications.
-Resident #14 took her medications and did not have any memory problems.

Interview with a second MA on 4/21/17 at 8:15 am revealed she always observed Resident #14 take her medications.

Interview with Resident #14 on 4/20/17 at 3:40 pm revealed:
-The MA staff observed her take her take her medications "about half the time."
-She always took her medications.
-Different MAs had given her medications, and it wasn't a particular MA that did not observe her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 366	Continued From page 25 take her medications. Interview with the Resident Care Coordinator on 4/21/17 at 10:15 am revealed she was not aware staff were not observing residents take their medications. Refer to review of the facility's Medication Aide Job Description. _____ Review of the facility's Medication Aide Job Description revealed: -MA are responsible for administration and minor treatments to residents as prescribed by a physician. -MA are responsible for properly documenting such medications and treatments. -MA are responsible for observation and documentation of response (therapeutic or adverse) to medications and treatments.	D 366		
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 imply the inability of the resident to self-administer medications.	D 376		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 376	Continued From page 26 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure compliance with the facility's policies and procedures for self-administration of medications for 2 of 3 sampled residents (#5 and #7) who were self-administering medications. The findings are: Review of the facility's policies and procedures for self-administration for medications revealed: -Residents who request approval to self-administer shall be assessed by the interdisciplinary team to determine if the resident is competent to self-administer medication. -The interdisciplinary team will assess the resident's cognitive, physical and visual ability to carry out this responsibility. If the team determines that the resident is competent, the attending physician shall be contacted to request a specific order for self-administration of the medication. -The facility shall assess for proper bedside storage. -The interdisciplinary team shall re-assess the resident's ability to self-administer every 3 months. -The staff are not required to document when a resident self-administers. -If the self-administration privileges are withdrawn, the physician shall be notified and the pharmacist asked to update the prescription records. Review of the facility's "Medication Self-Administration Assessment" form, attached to the self-administration policy, revealed the form was for documenting the resident's name, person completing the assessment, date completed, and	D 376		

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	HAL060139	A. BUILDING: _____ B. WING _____	C 04/21/2017

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D 376	Continued From page 27	D 376		

whether the resident was assessed for able to safely self-administer medications or unable to safely administer medications.

A. Review of Resident #5's current FL-2 dated 02/15/17 revealed:
-Diagnoses included dementia, diabetes mellitus, and hypertension (high blood pressure).
-The resident was intermittently disoriented.
-A physician's order to check fingerstick blood sugar (FSBS) from 1-5 times a day.
-No order for the resident to self-administer medications.

Review of Resident #5 record revealed:
-No subsequent physician's order for Resident #5 to self-administer FSBS.
-No "Medication Self-Administration Assessment" form completed for Resident #5 upon admission on 02/16/17.

Interview on 04/19/17, during the initial tour, at 10:55 am with Resident #5 revealed:
-Staff administered his medications routinely each day.
-Staff gave him an injection of his (Novolin) 70/30 insulin 2 times a day.(Novolin 70/30 is a combination of long acting and short acting insulin.)
-He checked his own FSBS, using his glucometer, at least 1 to 2 times daily.
-Staff did not check his FSBS.

Review of Resident #5's electronic Medication Administration Records (eMARs) for February, March, and April 2017 revealed an entry to check fingerstick blood sugar (FSBS) up from 1-5 times a day was not listed on the eMARS.

Interview on 04/19/17 at 4:00 pm with the

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D 376	Continued From page 28	D 376		

Resident Care Coordinator (RCC) revealed:
-She was not aware Resident #5 was self-administering his FSBS.
-She had not audited Resident #5's records for information regarding an order for Resident #5 to check his own FSBS.
-She had not audited Resident #5's record any information regarding the facility assessing the resident for self-administration.

Second interview on 04/19/17 at 4:30 pm with the RCC revealed:
-The Director of Nursing (DON) and nursing staff were responsible for monitoring the residents' records for completeness and the eMARs for accuracy.
-The DON and nursing staff were responsible to assure a "Medication Self-Administration Assessment" was completed for all residents who self-administered medications
-The facility had been without a DON for several months.
-The RCC was responsible for assuring "Medication Self-Administration Assessment" forms were completed while the DON position was vacant.

Telephone interview on 04/21/17 at 8:45 am with a representative for the contract pharmacy provider revealed:
-The pharmacy received a copy of Resident #5's FL-2 dated 02/15/17.
-The pharmacy was responsible to enter orders for the residents onto the eMAR.
-An order to check fingerstick blood sugar (FSBS) from 1-5 times a day was on the FL-2 but the pharmacy did enter the order on the eMAR.
-The pharmacy did not have an order for Resident #5 to self-administer medications, including FSBS checks.

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D 376	Continued From page 29 -She was unable to explain why Resident #5's order for FSBS checks was not entered onto the eMAR. -She stated the order would be added to the eMAR today (04/21/17). Interview on 04/21/17 at 9:38 am with Resident #5 revealed: -He took his FSBS at least 2 times daily, on his own. -He had been taking his FSBS for more than 15 years. -He had his own glucometer that he used to take his FSBS that he kept in his room. -He told the medication aide (MA) what his FSBS value was before he received his insulin injections twice each day. -He documented his FSBS values in a log book he kept in his room. -He did not know if the MA documented the FSBS value anywhere. -He informed the MA if his FSBS value was low (below 100), but he had not had a time recently when the FSBS value was below 100. The FSBS value was usually in the 200 range. -He informed the MA when he needed supplies, like glucometer test strips or alcohol swabs, and they brought them to his room. -The MA gave his is oral medications and administered his insulin 2 times a day. Interview on 04/21/17 at 10:15 am with a day shift MA revealed: -She routinely worked the day shift at least 5 days a week. -She administered medications to Resident #5 routinely when she worked. -Resident #5 did his own FSBS check. -Check FSBS for Resident #5 did not appear on the eMAR.	D 376		

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D 376	Continued From page 30	D 376		

-Resident #5 checked his own FSBS and always told her the reading before she administered his Novolin 70/30 insulin.
-She did not document the FSBS reading anywhere but asked the resident for his FSBS value and made sure the FSBS value given to her by the resident was over 100 before she administered his insulin.

On 04/20/17 at 5:30 pm, the Resident Care Coordinator presented an order from Resident #5"s primary care physician dated 04/20/17 as follows: "Patient can administer to check his own blood sugar levels 30 minutes before breakfast and 30 minutes before supper".

Refer to interview with the Executive Director on 04/21/17 at 4:00 pm.

B. Review of Resident #7's current FL-2 dated 07/06/16 revealed diagnoses of congestive heart failure, diabetes mellitus, hypertension, hyperlipidemia, vitamin D deficiency, chronic kidney disease, obesity, aortic valve replacement, overactive bladder, benign prostatic hyperplasia, history of basal cell sarcoma, osteoarthritis, and peripheral neuropathy.

Review of Resident #7's Resident Register revealed an admission date of 07/06/16.

Review of Resident #7's current medication orders listed on the FL-2 dated 07/06/16 included:
-Acetaminophen 500 mg 2 tablets every night at bedtime (may self-administer). (Acetaminophen is used to treat mild pain).
-Amlodipine 5 mg 1 tablet every day (may self-administer). (Amlodipine is used to treat high blood pressure).
-Atorvastatin 10 mg 1 tablet every night at

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D 376	Continued From page 31	D 376		

bedtime (may self-administer). (Atorvastatin is used to lower cholesterol).
-Cyanocobalamine Injection 1000 mcg Inject 1 ml intramuscularly every month. (Cyanocobalamine is used to supplement vitamin B12).
-Fenofibrate 134 mg 1 capsule every morning (may self-administer). (Fenofibrate is used to lower triglycerides).
-Furosemide 40 mg 1 tablet every day (may self-administer). (Furosemide is used to treat fluid retention).
-Lisinopril 10 mg 1 tablet every day (may self-administer). (Lisinopril is used to treat high blood pressure).
-Novolog 100/ml insulin 10ml FSBS twice a day, dose per sliding scale 151-250=2u, 251-300=4u, 301-350=6u, 351-400=8u, >400= call MD (may self-administer). (Novolog is used to treat elevated blood sugar).
-Vitamin D 1000 IU 1 tablet every morning (may self-administer). (Vitamin D is a vitamin supplement).

Review of a subsequent physician's order, dated 07/25/17 revealed an order "OK to self-medicate."

Review of Resident #7's record revealed:
-No documentation a "Medication Self-Administration Assessment" had been completed at admission on 07/06/16.
-No documentation a "Medication Self-Administration Assessment" had completed every 3 months per the facility policy.

Review of the March 2017 Medication Administration Record (MAR) and April 2017 MAR for Resident #7 revealed:
-There was no documentation on the MAR's that the resident's self-administered medications/orders were verified by the

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D 376	Continued From page 32 medication aide. Interview with Resident #7 on 04/19/17 at 3:30 pm revealed: -Resident #7 had been self-administering his medications for many years. -Resident #7 explained the type of medication, purpose for each medication and schedule for taking the medications he was prescribed during the interview. (Observation during the interview revealed all medications ordered were in the resident's room.) -A self-administration assessment had never been completed by facility staff. -Resident #7 told the medication aide when his medication was running low and the facility re-ordered his medications and brought them to his room. -Resident #7 had never had a facility staff check on his medications kept in his room. Refer to interview on 04/21/17 at 4:00 pm with the Executive Director. _____ Interview on 04/21/17 at 4:00 pm with the Executive Director revealed: -She had been Executive Director at the facility for about 3 months and had experienced a lot of staff turnover. -She was unaware of the discrepancies with the self-administration of medications for the residents. -It was the responsibility of the Resident Care Coordinator, Director of Nursing, and nursing staff to assure the facility policies and procedures for residents' self-administering medications were in compliance. -A new Director of Nursing had been hired and was scheduled to start work on 04/24/17.	D 376		