	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDTEAN	or dortheorion	IDENTIFICATION NOMBER.	A. BUILDING: _		OOM! L	-120
		HAL013044	B. WING		12/1	4/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	IG CENTER OF CONCOR	RD 160 WARRE	EN C. COLEM , NC 28027	AN BLVD.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	conducted an annual	sure Section and the partment of Social Services survey on December 11-13, ference via telephone on				
D 137	10A NCAC 13F .0407 Qualifications	'(a)(5) Other Staff	D 137			
	(a) Each staff person shall:(5) have no substant	7 Other Staff Qualifications n at an adult care home liated findings listed on the n Care Personnel Registry 1E-256;				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility fa sampled staff (Staff B	B and Staff D) had no s on the North Carolina				
	The findings are:					
	-She was hired on 04 (MA)She had no docume. Personnel Registry C completed prior to 12	, ,				
	revealed: -She was not aware of	of the facility doing a HCPR				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL013044	B. WING		12	2/14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
THE LIVIN	IG CENTER OF CONCOR	160 WAR	REN C. COLEMAN	I BLVD.		
1112 21411	- COLNIER OF CONCOR	CONCOR	RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 137	Continued From page	e 1	D 137			
	check on her prior to -She was not aware v	· ·				
	-She was hired on 11 Aide (PCA). -There was no docur	s personal record revealed: /30/17 as a Personal Care mentation of a Health Care heck (HCPR) completed				
	Attempted telephone interview with Staff D on 12/12/17 at 5:00 pm and on 12/13/17 at 10:00 am was unsuccessful.					
	3:06 pm revealed: -The Business Office of the staff records ar completenessHe could not explain Administrator did not check on Staff BHe remembered hav November 2017 beca involving Staff B and seen in Staff B's reco April for the same thin at the facilityHe is not sure where in AprilThere was no docum April 2017 or Novemb B had been reported Personnel Registry (I) knowledge of the eve completed within 5 da -A report was not filed	ring to check the HCPR in ause of an allegation resident abuse and had ard a previous allegation in an before he began working it went after he checked it mentation the allegations in per 2017 in regards to Staff to the Health Care HCPR) within 24 hours of ents and an investigation ary report to the HCPR.				
	incident in April or in large and the could not locate a large A HCPR was suppose					

Division of Health Service Regulation

STATE FORM 9899 Y1H911 If continuation sheet 2 of 71

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE	SURVEY
AND LEAVE CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		CON	LLTLD
	HAL013044	B. WING		12	/14/2017
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE LIVING CENTER OF CONCORD	160 WARF	REN C. COLEMA	AN BLVD.		
	CONCOR	D, NC 28027			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
The facility failed to ass (Staff B and Staff D) had Care Personnel Regist hire. The failure of the substantiated findings previous allegations of the safety of the reside and constitutes a Type The facility provided a follows: -Additional training with responsible for the HR qualifications. -Administrator/BOM shemployee files to ensure gulations and facility. The use of an employe implemented and used file and employee files ensure compliance. Administrator/designed employee files audits in randomly thereafter to compliance per regulations and Director random employee files are being followed. CORRECTION DATE 1	sure 2 of 6 sampled staff ad a North Carolina Health try check prior to date of facility to know if staff had and after Staff B had 2 fabuse was detrimental to ents for neglect and abuse B Violation. Plan of Protection as the managerial staff that are files regarding other staff and conduct audits of the compliance per policy. The energy of the policy of the will perform random monthly x 6 months, then ensure continued tion and facility policy. The will conduct monthly audits to ensure policies	D 137			

Division of Health Service Regulation

STATE FORM 9899 Y1H911 If continuation sheet 3 of 71

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/1	4/2017
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE. ZIP CODE		
THE LIVIN	G CENTER OF CONCOR	160 WAR	REN C. COLEMA			
I HE LIVIN	G CENTER OF CONCOR	CONCOR	D, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 257	Continued From page	e 3	D 257			
D 257	10A NCAC 13F .0801	(d) Resident Assessment	D 257			
	(d) If a resident expe as defined in Paragra facility shall refer the physician or other app professional such as professional, nurse polassistant or registered consistent with the relonger than 10 days for and document the referecord. Referral shall significant changes as immediate risk to the	ractitioner, physician d nurse in a timely manner sident's condition but no rom the significant change,				
	failed to refer 1 of 1 s day weight loss great the physician or anoth health professional w the weight loss (Resident # 7/27/17 revealed diag chronic obstructive pu osteoarthritis, hyperlin diverticulitis, and histo Review of Resident # Record for 2017 reve -Resident's recorded was 153 pounds.	and record review, the facility ampled resident with a 30 er than 5% of body weight to her appropriate licensed ithin 10 days of identifying dent #4). 4's current FL2 dated gnoses of hypertension, ulmonary disease, bidemia, history of ory of alcohol abuse.				

Division of Health Service Regulation

-Resident's recorded weight for December 2017

STATE FORM 6899 Y1H911 If continuation sheet 4 of 71

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL013044	B. WING		12/14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		160 WARR	EN C. COLEMA	AN BLVD.	
THE LIVIN	IG CENTER OF CONCOR	RD	, NC 28027	52.75.	
	CLIMMA DV CT	ATEMENT OF DEFICIENCIES	1	PROVIDENCE DI ANI OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 257	Continued From page	e 4	D 257		
	was 134 pounds.				
		gnificant weight loss of 7% mber 2017 and 7% weight o December 2017.			
	Review of Resident #4's record revealed there was no documentation Resident #4's physician had been contacted regarding significant weight loss.				
	revealed: -She defined significations within 1 month at monthsIt was the facility Resigner (RCC) responsibility to the was made aware Resident #4 had signed Resident #4's monthly a surveyorResident #4's physicand was made aware some was not aware in communication with Fregarding weight loss -Documentation of an physician should have recordThere was also a segnotes were kept, but some policy for the position of any significant weight loss for any significant weight loss of any signif	ant weight loss as 5% weight and 10% weight loss within 6 sident Care Coordinator's or review monthly weights. The today 12/12/17 that ifficant weight loss after by weights were requested by the ian was in the building today of her weight loss. If there had been any prior Resident #4's physician prior to today. The prior to today been kept in Resident #4's the parate notebook where she could not locate the only sician to be made aware			
	_	2/17, and was made aware			
	of Resident #4's weig				

Division of Health Service Regulation

STATE FORM 6899 Y1H911 If continuation sheet 5 of 71

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
74101 2741	or dorate of the transfer of t	IDENTIFICATION NO MIDEN.	A. BUILDING: _		J SOINII EE TEB	
		HAL013044	B. WING		12/14/20	17
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	G CENTER OF CONCOR	RD	EN C. COLEMA	AN BLVD.		
		CONCORD	, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CO	(X5) MPLETE DATE
D 257	Continued From page	e 5	D 257			
	3:52 pm revealed: -She was not aware of since October 2017 uthe facilityShe would expect to ongoing weight loss is					
	Interview with the Administrator on 12/12/17 at 4:07 pm revealed: -He was not aware of Resident #4's weight loss since October 2017 until todayHe expected Resident #4's physician to have been notified in November 2017 regarding her weight lossThe RCC was responsible for contacting Resident #4's physician to report weight loss.					
	revealed: -She had been working September 2017She was not aware Five weight loss since Octular -It was her responsible weights"I try to review them -The medication aided documenting monthly physician if there was	every month." s (MA) were responsible for weights and contacting the significant weight loss. Resident #4's physician had				
	revealed: -It was the MA's responsible weights and documer recordThe RCC was responsible.	on 12/12/17 at 4:48 pm onsibility to check monthly nt them on the vital signs nsible for reviewing the reporting significant weight				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12	/14/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	-		
THE LIVIN	IG CENTER OF CONCOR	RD.	REN C. COLEMA D, NC 28027	AN BLVD.			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 257		Resident #4 had weight loss. Inted or reported any weight	D 257				
D 273			D 273				
	reviews, the facility fa follow up with the phy residents (Resident # physician orders for s medications; (Reside	ns, interviews, and record iled to assure referral and sician for 5 of 10 sampled 2, #9, and #8) regarding elf-administration of int #4) regarding use of ident #11) regarding a					
	3/7/17 revealed diagn hypertension, stroke, Review of Resident # -There was no order of the Resident #2 to se medications. -There was a standing Imodium AD 2 mg (mosymptoms of diarrhea	#2's record revealed: or evaluation completed for					

Division of Health Service Regulation

STATE FORM 6899 Y1H911 If continuation sheet 7 of 71

DIVISION	or riealin Service Regu	lation				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	<u>-</u> D
		HAL013044	B. WING		12/14/2	2017
		TIALUTOUT			12/14/2	2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE 1 15/18	IC CENTED OF CONCOR	160 WAR	REN C. COLEM	AN BLVD.		
I HE LIVIN	IG CENTER OF CONCOR	CONCOR	D, NC 28027			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEI IOIENOT)		
D 273	Continued From page	e 7	D 273			
	physician for paraieta	nt diarrhae (24 haura)				
	physician for persiste	nt diarrhea (24 hours).				
	Interview with Reside	nt #2 on 12/12/17 at 10:40				
	am revealed:	110 112 011 12/12/17 dt 10.10				
	-He had some over-th	ne-counter (OTC)				
		om that he administered to				
	himself, purchased by	y his brother and				
	sister-in-law.					
	-He could not remem	ber how long he had these				
	medications in his roo					
	-His doctor did not pre					
		lid not make her aware that				
	he was taking them.					
		oom that he administered to				
		ce he had recovered from				
	colon cancer.	he rubbed on his body to				
	help relieve pain whe	_				
		medication he administered				
	whenever he had a he					
		tions in his room because				
		administer medications.				
		been removed by staff				
	during the evening or	•				
	Telephone interview v					
		P) on 12/12/17 at 9:25 am				
	revealed:					
		ons were purchased for				
	Resident #2 because					
	administer medication	ns at times. The string in the string is at times.				
		ever remembered purchasing				
		#2 to keep in his room for				
	diarrhea.					
		nber if the facility had a				
	policy on self-adminis					
		ian had not been prescribed				
		cations she purchased.				
		staffshe purchased OTC				

Division of Health Service Regulation

STATE FORM 6899 Y1H911 If continuation sheet 8 of 71

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING:				
			D. MINO			
		HAL013044	B. WING		12	2/14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
THE LIVIN	G CENTER OF CONCO	RD	RREN C. COLEMAN	I BLVD.		
		CONCO	RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 8	D 273			
	medications for resid	ent.				
	· ·	I (MAR) for October, ember 2017 revealed there ny of the OTC medications				
	documentation his ph the resident had OTO	#2's record revealed no hysician had been notified medication in his room ministering and no physician histering medications.				
	medications removed the facility revealed: -The medications wh were in a box with Renumber written with a - A 4 ounce (oz.) tube (medication used to rpain). -15 soft gel tablets of (medication used to the bloating). -A 3 oz. tube of maxic cream (medication used to the bloating). -100 tablets of ibuprorelieve pain, reduce for the soft medication used to the bloating).	e of ultra-strength muscle rub muscle aches and arthritis if 125 mg simethicone treat gas pain, pressure, and mum strength thera-gesic sed to relieve pain). In offen (medication used to rever). m AD (medication used to diarrhea) f Vapor Rub (medication				
		Resident #2 was				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL013044	B. WING		12/14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
THE LIVIN	G CENTER OF CONCOR	160 WAR	REN C. COLEMA	AN BLVD.	
1112 214114	- COLITIZATION CONTROL	CONCOR	D, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 273	Continued From page	9	D 273		
	-If Resident #2 continumedication, he would imbalanceAll other OTC medic self-administered workealthShe expected the factorial could assess the resion of medicationShe had not been not facility that Resident #3 OTC medications. Interview with the Me 12/12/17 at 3:45 pm resident #2She had never seen Resident #2's roomShe was not aware to administering his owreshe administered Relisted on the MARShe had never check OTC medications. Interview with the Peron 12/13/17 at 10:58 -She removed OTC medications. Interview with the Peron 12/13/17 at 10:58 -She removed OTC medications. Interview with the Peron 12/13/17 at 10:58 -She removed OTC medications. She had not notified because she was not anyone after removing medications.	ued to take Imodium be at risk for an electrolyte ations Resident #2 ald cause no harm to his cility to notify her so she dent for self-administration offied by anyone at the #2 was self-administering dication Aide (MA) on revealed: edications during 1st shift for any OTC medications in that Resident #2 was medications. esident #2's medications as a ked Resident #2 room for resonal Care Assistant (PCA) am revealed: medications from Resident on the process of the medications. cations, she left them in the arter to review. Resident #2's physician instructed to contact g the medications.			
	because she was not anyone after removin	instructed to contact g the medications.			

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-MA's were responsible for administering

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE S		
			A. BOILDING			
		HAL013044	B. WING		12/1	4/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	IG CENTER OF CONCOR	RD	EN C. COLEMA D, NC 28027	AN BLVD.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDEFICIENCY)	D BE	(X5) COMPLETE DATE
D 273	had not notified the p -She would call the fa were any changes wi Interview with the Adr 11:35 am revealed: -He was not aware th medications in their ro medications from roo -The RCC was respo doctor of self-adminis -He was unsure if the notified that the Resid medications and were -Residents and famili admission that the res medications to MA or and cannot be admin 2. Review of Resider 6/12/17 revealed diag diabetes, hypertensio chronic kidney diseas ischemic attack. Review of Resident # -There was no order of the Resident #9 to se medicationsThere was a standin Tylenol 500 mg 2 tabl for 24 hours, notify ph than 24 hours.	Resident #2 was adications. of medications being ident #2 room therefore she hysician or families. umily or physician if there th medications. ministrator on 12/13/17 at at Resident #2 had OTC com, until a PCA removed m. unsible for notifying the stration of medications. doctor or family had been dent #2 was administering a removed from his room. es were notified during sident must give RCC to be administered istered without an order. In #9's current FL-2 dated gnoses included type 2 on, hyperlipidemia, anemia, se, and history of transient 9's record revealed: or evaluation completed for	D 273			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLI	
			-			
		HAL013044	B. WING		12/1	4/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	G CENTER OF CONCOR	RD	REN C. COLEM	AN BLVD.		
	OLUMBA DV OT		RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 11	D 273			
	administered to himsel-He had several medicough medicine and neededHe could not remem medications he had in -The medications were 12/11/17 by 3 staff medications in his room-He administered the he felt that he needed -The OTC medication daughterHe thought he was constituted.	cations which included a Tylenol he used when he ber exactly how many h his room. re removed at 2:00 am on embers. ber how long he had these om. OTC medication whenever				
	revealed: -OTC medications we #9 because she felt F administering his owr -She purchased OTC #9 and did not notify st the roomShe could not rement she purchasedShe could not rement policy on self-administ- Resident #9's physic of the OTC medicatio -She had not notified was self-administering	ere purchased for Resident Resident #9 was capable of a medications. medications for Resident staff the medications were in aber when and exactly what the facility had a stration. ian had not prescribed any ns she purchased. the physician the resident g OTC medications.				
	Review of Resident #	9's medication				

Division of Health Service Regulation

administration record (MAR) for October,

STATE FORM 6899 Y1H911 If continuation sheet 12 of 71

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY OMPLETED	
		HAL013044	B. WING		12	2/14/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	•	-
TO WILL OF T	NOVIDEN ON OUT FIELD		RREN C. COLEMAN			
THE LIVI	NG CENTER OF CONCO	RD	RD, NC 28027	. 5275.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	November, and December of Resident #9 reported Review of Resident and OTO he was self-administ order's for self-administration with a formal for self-administration used to -14 tablets of 1200 in dextromethorphan (Acontrol cough) -3 Salonpas Gel Paticapsaicin and 1.25% to relieve pain)0.33 oz. bottle of how (medication used to -A 4.7 oz. tube of Asirolamine salicylate (pain)1 Icy-Hot patch medication used to -100 ibuprofen tablet pain, reduce fever).	ember 2017 revealed there ny of the OTC medications d. #9's record revealed no hysician had been notified C medication in his room that ering and no physician histering medications. 13/17 at 11:00 am of a box of d from resident's rooms by hich belonged to Resident #9 esident's name and room a permanent marker. Aline nasal spray (medication asal passages). Idets of extra strength 500 mg dication used to relieve pain). In saline nasal spray soothe dry nasal passages). In guifenesin and 60 mg Also called Mucinex used to ches containing 0.025% of menthol (medication used meopathic ear ache drops relieve ear discomfort). Percreme containing 10% medication used to treat thicated with menthol 5% relieve pain). Is (medication used to relieve of Vapor Rub (medication used to relieve for the containing to the contain	D 273			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		HAL013044	B. WING		12/14/2017
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
THE 1 13/151	O CENTED OF CONCOR	160 WARF	REN C. COLEMA	AN BLVD.	
THE LIVIN	G CENTER OF CONCOR	CONCOR	D, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 13	D 273		
	-20 tablets of 125 mg	simethicone (medication			
	•	, pressure, and bloating).			
	Intension, with a name	from Decident #01e minery			
	care physician's office	e from Resident #9's primary e revealed:			
	-The primary care phy	ysician (PCP) was not aware			
	that resident was self- medications.	-administering OTC			
	-The PCP felt Reside	nt #9 was capable of			
	administering his own	medications.			
	-The PCP expected to	be notified with any ns or requests regarding			
	medications.	ns or requests regarding			
		edication Aide (MA) on			
	12/12/17 at 3:45 pm r -She administered me	edications during 1st shift for			
	Resident #9.	-			
	Resident #9's room.	any OTC medications in			
	-She was not aware the				
	administering his own -She administered Re	n medications. esident #9's medications as			
	listed on the MAR.				
	 She had never check OTC medications. 	ked Resident #9 room for			
	OTO MEGICALIONS.				
		sonal Care Assistant (PCA)			
	on 12/13/17 at 10:58	am revealed: nedications from Resident			
		017 because residents did			
		self-administer medications.			
	 After removing media office for the Administ 	cations, she left them in the			
		rator to review. Resident #2 or Resident			
	#9's physician becaus	se she was not instructed to			
	contact anyone after i	removing the medications.			

Division of Health Service Regulation

Interview with the Resident Care Coordinator (RCC) on 12/12/17 at 5:30 pm revealed:

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING: _			
		HAL013044	B. WING		12/14	1/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
THE LIVING CENTER OF CONCORD			EN C. COLEMA), NC 28027	AN BLVD.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 273	had not notified the p -She would call the fa were any changes wi Interview with the Adr 11:35 am revealed: -He was not aware th medications in their ro medications from roo -The RCC was respo doctor of self-adminis -He was unsure if the notified that the Resio medications and were -Residents and famili admission that the res medications to MA or	ole for administering ons. Resident #9 was dications. of medications being ident #9 room therefore she hysician or families. amily or physician if there th medications. ministrator on 12/13/17 at at Resident #9 had OTC com, until a PCA removed m. nsible for notifying the stration of medications. doctor or family had been dent #9 was administering e removed from his room. es were notified during	D 273			
	revealed: -Diagnoses included fibrillation, anxiety, ar -There were no media	nt #8's current FL2 6/26/17 dementia, depression, atrial and coronary artery disease. cation orders for lubricant biotic ointment, antiseptic mointment.				
	Review of Resident # revealed: -There was a physicia solution 1.4 %, instill	8's record on 12/13/17 an's order for artificial tears one drop in both eyes four d for dry eyes (wait 3-5				

Division of Health Service Regulation

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL013044	B. WING		12/14/2017
THE LIVING CENTER OF CONCORD 160 WARR			DRESS, CITY, STAREN C. COLEMA D, NC 28027	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 273	minutes between difference was no order in medication. There was no documn assessment for self-area was no documn assessment for self-area was an order in order for patient to set tears. There was no order in order in order was no order in o	erent eye drops). to self-administer any nentation of a cognitive administration of medication. 8's 6 month physician revealed: for artificial tears and an elf-administer the artificial for triple antibiotic ointment, nentholatum ointment. for self-administration of any 8's Medication d (MAR) for October, mber 2017 revealed: tears solution 1.4%, instill 1 r times daily as needed. es for triple antibiotic vipes, or mentholatum nt #8 on 12/13/17 at 9:05 my room and stole my eye drops and couldn't find no took them." cought the eye drops for her. for dry eyes. ether residents came in her me drops in their eyes if they	D 273		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/1	4/2017
	ROVIDER OR SUPPLIER	160 WARR	DRESS, CITY, STA EEN C. COLEMA D, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	9:29 am revealed: -He had a Medication over-the-counter (OT resident's room after resident's room"This was not the firs medication from residabout once a month." -He was not aware Remedication in her roodHe was not aware Recomplaining about had out of her roomHe assumed that Rebrought the medication-He did not know if Reassessment complete capable of self-administer medication-He did not know if Reassessment complete capable of self-administer medication-Residents and familial admission that any O given to the MAThe Resident Care Oresponsible for ensurity self-administer medications who kept OroomsThe RCC was in the residents' physicians who had been taking found in their rooms. Observations on 12/1 medications removed the facility revealed: -There were two 0.5 ferminister were two 0.5 ferminis	Aide (MA) to collect C) medications from each a cream was identified in a set time we have removed lent's rooms. We do this esident #8 had any OTC m. esident #8 had been ving her eye drops taken sident #8's family members on into the facility for her. esident #8 had a cognitive ed to show that she was istering her medication. es were notified upon TC medication must be Coordinator (RCC) was ing that a physician's order dication was in place for TC medications in their	D 273			

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in the original packaging with Resident #8's name

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL013044	B. WING		12/1	4/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	G CENTER OF CONCOR	RD	EN C. COLEMA	AN BLVD.		
	OLUMBA DV OT), NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 17	D 273			
D 273	and room number wri -There was a 1 ounce ointment (used to pre Resident #8's name a itThere was 1 count p to prevent infections) and room number wri -There two 1 ounce o ointment (used to reli pain) with Resident # written on them. A second interview w at 10:16 revealed: -"I'm supposed to tak day." -The eye drops were of her bedside table"I didn't give the eye them." -"I did have a good bi and got it all out." -She called her family someone took her ey -Resident #8's family staffShe did not know if h order for her to self-a Interview with a MA or revealed -She was not aware i medication in her roo -She was not aware i self-administering any physician's order to self-a	itten on it. e tube of triple antibiotic event infections) with and room number written on eack of first aide wipes (used with Resident #8's name itten on it. containers of mentholatum eve minor muscle and joint i8's name and room number ith Resident #8 on 12/13/17 e the eye drops 3 times a covered up in the top drawer drops to anyone. They took it of medicine, but they came by member and told her e drops. member told her to tell the ener physician had written an dminister her medication. on 12/13/17 at 10:23 am f Resident #8 was y medication or had a elef-administer medication.	D 273			
	medication to be kept	nave a physician's order for tin her room. sponsibility to ensure that a				

Division of Health Service Regulation

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
		1101.040044	B WING	B. WING		4/0047
		HAL013044			12/1	4/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		160 WAR	EN C. COLEM	AN BIVD		
THE LIVIN	IG CENTER OF CONCOR	RD	D, NC 28027	52.75.		
			7, 140 20027	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD)		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
			 			
D 273	Continued From page	e 18	D 273			
	physician's order to se	elf-administer medication				
		OTC medications kept in a				
	resident's room.					
	10010011101101111					
	Interview with a family	y member of Resident #8 on				
	12/13/17 at 10:23 am					
	-She received a call fi	rom Resident #8 stating that				
	someone "stole her e					
		the eye drops and other				
		lent #8 to keep in her room.				
		note" from her doctor stating				
		er eye drops in her room.				
	-	ne staff she had brought in				
	the other OTC medica	_				
	-She was not aware F					
	physician's order for (
		loved Resident #8's OTC				
	medication from her r					
		John III and past				
	Interview with a secon	nd MA on 12/13/17 at 2:30				
	pm revealed:					
	-She was not aware F	Resident #8 had OTC				
	medications in her roo					
	-She did not know if F	Resident #8 had a				
		elf-administer medication.				
		nedication was found in a				
		MA or RCC would take the				
		resident's room and contact				
	the physician.	redicente room and contact				
	Interview with the RC	C on 12/13/17 at 2:36 pm				
	revealed:					
	-She was not aware F	Resident #8 had OTC				
	medications in her roo					
	-She was not aware it					
	physician's order to se	elf-administer medication or				
	• •	nent had been completed for				
	_	e to safely self-administer				
	medication	,				

Division of Health Service Regulation

-She was responsible for ensuring physician

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING: _			
		HAL013044	B. WING		12/14	4/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE LIVING CENTER OF CONCORD			EN C. COLEMA , NC 28027	AN BLVD.		
	OLIMANA DV. OT		1	DDOWNED DIAN OF CORRECTIO		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 273	Continued From page	e 19	D 273			
	obtained and for ensult was completed every self-administered med-She had not contacte to obtain an order to shad a cognitive assess. Telephone interview which was physician's office revealed: -The physician was not self-administering meder to self-administering meder to self-administer the mederate self-administer the mederate self-administer the self-administer the mederate self-administer the self-administer the mederate self-administer the self-a	ed Resident #8's physician self-administer medication or assment completed. with a nurse from Resident e on 12/14/17 at 2:52 pm ot aware Resident #8 was edications.				
	7/27/17 revealed: -Diagnoses included obstructive pulmonary -The medication orde	rs included Ventolin inhaler, alation 4 times daily as				
	physician if Resident	ed 8/31/17 to notify the				

Division of Health Service Regulation

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/1	4/2017
	ROVIDER OR SUPPLIER	160 WARR	RESS, CITY, STA En C. Colema , NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	revealed: -An entry for Ventolin 4 times daily as need -Ventolin was docume times during the weel -Ventolin was docume times during the weel 10/14/17Ventolin was docume times during the weel 10/21/17Ventolin was docume times during the weel 10/28/17Ventolin was docume times during the weel 10/28/17Ventolin was docume times from 10/29/17 to the weel 10/28/17Ventolin was docume times from 11/1/17 the ventolin was docume times from 11/1/17 the ventolin was docume times during the weel 11/18/17Ventolin was docume times during the weel 11/18/17Ventolin was docume times during the weel 11/25/17. Review of Resident # revealed: -An entry for Ventolin 4 times daily as need -There were no docured.	4's Medication d (MAR) for October 2017 inhaler 2 puffs via inhalation ed. ented as administered 7 of 10/1/17 through 10/7/17. ented as administered 7 of 10/8/17 through ented as administered 5 of 10/15/17 through ented as administered 4 hrough 10/31/17. 4's MAR for November 2017 inhaler 2 puffs via inhalation ed. ented as administered 4 rough 11/4/17. ented as administered 5 of 11/12/17 through ented as administered 4 rough 11/4/17. ented as administered 5 of 11/12/17 through ented as administered 5 of 11/19/17 through ented as administered 4 of 11/19/17 through 4's MAR for December 2017 inhaler 2 puffs via inhalation ed. mented entries where tolin exceeded 3 times a	D 273			

Division of Health Service Regulation

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DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL013044	B. WING		40/44/2047	
		HAL013044			12/14/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
THE 1 15/15	10 OFNITED OF CONCOR	160 WAR	REN C. COLEM	AN BLVD.		
I HE LIVIN	IG CENTER OF CONCOR	CONCOR	D, NC 28027			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				DEI IOIENOT)		
D 273	Continued From page	e 21	D 273			
	Further review of Res	sident #4's record revealed				
	no documentation Re	sident #4's physician had				
	been notified that Res	sident #4 needed to use				
	Ventolin Inhaler more	than 3 times weekly.				
	Interview with Reside	nt #4 on 12/11/17 at 10:26				
	am revealed:					
	-She had a diagnosis					
		when she became short of				
	breath, usually in the	_				
	-She only used one in	nhaler.				
	Interview with a first s	shift Medication Aide (MA) on				
	12/12/17 at 9:40 am r	· · ·				
	-Resident #4 had an	emergency inhaler to use as				
	needed for shortness	of breath.				
	-She had not adminis	tered the emergency inhaler				
	to Resident #4 during					
		he physician needed to be				
		was used more than three				
	times a week.					
	-It was Resident Care	` '				
	•	act the physician regarding				
	medication.					
		gional RCC on 12/12/17 at				
	12:13 pm revealed:					
	-She had been working 11/13/17.	ng at the facility daily since				
		of Resident #4's order for the				
		cted if Resident #4 needed				
	• •	haler more than 3 times a				
	week.					
		d to be contacted, staff				
		note in the resident's record				
	to document the com	munication with the				
	phyisican.					
		separate notebook where				
	staff notes were kept,	, but we can't find it."				

Division of Health Service Regulation

-It was the RCC's responsibility to contact the

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
7.1101 1.111	or Contraction	BENTIN IO MISON NOMBER.	A. BUILDING: _	A. BUILDING:		-125	
HAL013044		HAL013044	B. WING		12/1	4/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AP	DRESS, CITY, STA	TE ZIP CODE		-	
TVAWL OF T	KOVIDEIK OK OOI I EIEK		REN C. COLEMA				
THE LIVIN	G CENTER OF CONCOR	RD.	D, NC 28027	AN DEVD.			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE	
D 273	Continued From page	22	D 273				
	physician regarding a	ny issues with medications.					
	(PA) on 12/12/17 at 3 -Resident #4 had bee -She had not received facility regarding med 2017She was not aware \(\) administered more th Resident #4She would have expr Resident #4 was usin times a weekResident #4 needed inhaler due to her exc Interview with the Adr 4:07 pm revealed:	In stable. If any phone calls from the ications since October Ventolin inhaler was being an 3 times a week to ected to been notified that g Ventolin more than 3 It be put on a maintenance eess need for Ventolin.					
	physician to be contathe Ventolin inhaler mander more did not know if the phase of	ontacting the physician with s. C on 12/12/17 at 4:15 pm er current position since that Resident #4 had been inhaler more than 3 times a of the order for the physician sident #4 needed Ventolin					

Division of Health Service Regulation

-MAs were responsible for contacting the

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HAL013044 B. WING	12/14/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE LIVING CENTER OF CONCORD 160 WARREN C. COLEMAN BLVD.	
CONCORD, NC 28027	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
D 273 Continued From page 23 physician with medication issuesShe was not aware if the physician had been contacted regarding Resident #4 needing Ventolin inhaler more than 3 times a weekDocumentation of any contact with Resident #4's physician would have been kept in the resident record or on the physician's communication log which was checked by the physician or PA when they were in the building. Review of the facility physician communication log on 12/13/17 revealed no notes for the physician regarding use of Ventolin inhaler more than 3 times a week by Resident #4. E. Review of Resident #11's current FL2 dated 8/3/1/17 revealed: -Diagnoses included cerebellar atrophy, seizure disorder, schizophrenia, anemia, mild mitral valve regurgitation, and unsteady gaitThere was a physician's order for a regular mechanical soft (MS) diet. Review of the therapeutic diet list provided by the Dietary Manager dated 8/29/17 revealed Resident #11 was to be served a regular MS diet. Review of Resident #11's 6 month physician's orders dated 12/7/17 revealed an order for a regular MS diet. Review of the regular menu for the lunch meal service on 12/12/17 revealed the following items were to be served: -One piece of fried chickenOne serving of mashed potatoes with brown gravyOne serving of mixed vegetablesOne wheat dinner roil/bread.	

Division of Health Service Regulation

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DIVISION	n nealth Service Regu	iation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL013044	B. WING		12/14/2017
					12/14/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
THE LIVIN	G CENTER OF CONCOR	160 WAR	REN C. COLEM	AN BLVD.	
		CONCOR	D, NC 28027		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
TAG	REGOLATORT ORT	100 IDENTIFY TING IN CHAINATION	TAG	DEFICIENCY)	
D 070	- · · · -		D 070		
D 273	Continued From page	24	D 273		
	-One serving of vanill	a ice cream.			
	-A beverage of choice				
		eutic diet spreadsheet for			
		for the lunch meal service			
		the following items were to			
	be served:				
	-One serving of groun				
	-	ed potatoes with brown			
	gravyOne serving of greer	hoone			
	-One wheat dinner ro				
	-One pat of margarine				
	-One serving of vanill				
	-A beverage of choice				
	7 t bo vorago or orioloc				
	Observation of the lur	nch meal service on			
	12/12/17 at 11:00 am	revealed:			
	-Resident #11 was of	fered a meal consisting of			
	ground fried chicken,	mashed potatoes, brown			
		a roll with margarine, vanilla			
	ice cream and tea.				
		staff, "What's that? I want			
	what she has."	d 4 d d			
	•	d to a regular plate with a			
	grilled chicken breast	eal from Resident #11 and			
		meal consisting of a grilled			
	•	ed potatoes, brown gravy,			
		oll with margarine, vanilla			
	ice cream and tea.	and the game, value			
		p Resident #11's chicken			
		11 said "no" twice to staff			
	cutting her meat up.				
		out 50% of her meal and had			
	no difficulty with swall				
		tary Manager on 12/12/17 at			
	9:01 am revealed:	leff			
	-He and the dietary st	taff were employed by a			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		HAL013044	B. WING		12/1	4/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		160 WARRI	EN C. COLEMA	AN BLVD.		
I HE LIVIN	G CENTER OF CONCOR	CONCORD	, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	25	D 273			
	contracted company a preparing and serving menus. -It was the responsibility place food on residenthe resident's diet ordinate and their therapeutic of and their therapeutic diet food line. -He was aware Resid order for a MS diet. -Resident #11 refused the instructed staff to diet and if she refused meal. -He and dietary staff of Resident #11 refused the instructed staff to diet and if she refused meal. -He and dietary staff of Resident #11 refused the and the staff to diet and if she refused meal. -He and dietary staff of Resident #11 refused the staff to diet and if she refused the staff to diet and	and was only responsible for a food according to the lity of the dietary staff to t's meal trays according to ers. ed on a card behind the ed each resident's name diet. It items were on the serving ent #11 had a physician's diet eat a MS diet. Serve Resident #11 a MS diet then serve her a regular did not document when to eat a MS diet. It ity of the facility staff to ohysician, and to ensure oriate diet orders. Ity staff Resident #11 had resident #11 had resident #11 had resident #11 had resident #11 on 12/12/17 at 2:47 ecial diet. Wallowing test performed or a MS diet. 2/12/17 was the first time ren chopped meat. Istake." It difficulties with eating or same food as everyone				
	-She would not eat he	er meats chopped.				

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Interview with a Personal Care Aide (PCA) on

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIRED FY FULL REGULATORY OR LSC IDENTIFYMS INFORMATION) D 273 Continued From page 26 12/12/17 at 2:56 pm revealed: -She had worked at the facility for 3 weeksShe usually served meals in the dining hall during her shiftResident #11 was on a "chopped" dietShe served meal trays to Resident #11 that were prepared by the dietary staffThe Dietary Manager instructed the facility staff serving in the dining hall to put the physician ordered meal in front of Resident #11 and if she refused it to then give her what she wanted to eatShe had told the Administrator, Medication Aides (MA) and the Resident Ear Coordinator (RCC) that Resident #11 had been refusing her MS dietShe did not know if the physician had been contacted regarding Resident #11 refusing her MS dietShe was not very familiar with Resident #11She had not been notified Resident #11 had been refusing to eat a MS diet and was eating a	STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD 160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027 [(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 26 12/12/17 at 2:56 pm revealed: -She had worked at the facility for 3 weeksShe usually served meals in the dining hall during her shiftResident #11 was on a "chopped" dietShe served meal trays to Resident #11 that were prepared by the dietary staffThe Dietary Manager instructed the facility staff serving in the dining hall to put the physician ordered meal in front of Resident #11 and if she refused it to then give her what she wanted to eatShe had told the Administrator, Medication Aides ((MA) and the Resident #11 had been refusing her MS dietShe did not know if the physician had been contacted regarding Resident #11 refusing her MS dietInterview with Resident #11's Physician Assistant (PA) on 12/12/17 at 3:52 pm revealed: -Resident #11 had an order for a MS dietShe was not very familiar with Resident #11She had not been notified Resident #11 had been refusing to eat a MS diet and was eating a							
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been refusing to eat a MS diet and was eating a							
regular diet			a MS diet and was eating a				
regular dietThe facility may have notified the physician, but			e notified the physician, but				
she was not aware if they had.							
-There was a concern with aspirating if the diet			n with aspirating if the diet				
order was for MSShe expected to be notified if a resident refused			notified if a regident refused				
a MS diet so that the diet order could be		•					
re-evaluated.			4.0. 0. 40. 004.4				
Interview with the Administrator on 12/12/17 at 4:07 pm revealed:			ministrator on 12/12/17 at				
-He was not aware Resident #11 had been		-	desident #11 had been				
refusing to eat a MS diet as ordered by the		-	diet as ordered by the				
physicianThe RCC was responsible for contacting the			onsible for contacting the				

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Resident #11's physician to report she had been

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SU COMPLE		
ANDIEAN	or doring of the state of the s	IDENTIFICATION NOMBER.	A. BUILDING: _		J JOHN LL	ILD
		HAL013044	B. WING		12/14	1/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	G CENTER OF CONCOR	RD	REN C. COLEMA	AN BLVD.		
		CONCORI	D, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
D 273	D 273 Continued From page 27		D 273			
	noncompliant with the He was not aware if notified Resident #11 diet. -Resident #11's physinotified she was refus resident was eating a He was usually made during daily clinical st Resident #11's diet wattention. Interview with the RC revealed: -She has worked in h 2017She was responsible diet list and making so aware of any changes refusing to eat a MS or regular dietShe did not know if a Resident #11 was refusing to eat a MS or regular dietShe did not know if a Resident #11 was refusing to eat a MS or regular dietShe did not know if a Resident #11 was refusing to eat a MS or regular dietShe did not know if a Resident #11 was refusing to eat a MS or regular dietShe did not know if a Resident #11 was refusional resident #11 was refusional resident #11 was not she did not contact to	e MS diet order. the physician had been was refusing to eat a MS cian should have been sing to eat a MS diet and the regular diet. e aware of clinical issues and up meetings, but as never brought to his C on 12/12/17 at 4:15 pm er position since September e for updating the therapeutic ure that the dietary staff was is in diet orders. dered a MS diet. Resident #11 had been diet and was being served a any other staff were aware using to eat a MS diet. used to eat a physician sess was to make the ask for recommendations lity to notify the physician t following the ordered diet. the physician regarding				
	aware Resident #11 v MS diet. Review of the regular	rder because she was not was not eating the ordered menu for the dinner meal evealed the following items e and sausage soup.				

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HAL013044 B. WING	12/14/2017
·	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE LIVING CENTER OF CONCORD 160 WARREN C. COLEMAN BLVD.	
CONCORD, NC 28027	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273 Continued From page 28 -Two saltine crackersOne deli sandwich with whole slices of meatOne serving of spring mix with dressingOne serving of chilled peachesA beverage of choice. Review of the therapeutic diet spreadsheet for MS diets to be served for the dinner meal service on 12/12/17 revaled the following items: were to be served: -One bowl of cabbage and sausage soupTwo saltine crackersOne turkey salad sandwichOne serving of shredded lettuce with dressingOne serving of chilled peachesA beverage of choice. Observation of the dinner meal service on 12/12/17 at 4.45 pm revealed: -Resident #11 stopped a dietary staff member and stated, "I want a regular sandwich with wheat bread. I don't want that there (pointing to a turkey salad sandwich)." -The dietary staff served Resident #11 a deli sandwich with whole slices of meat, peaches, and teaA turkey salad sandwich was not offered to Resident #11. Interview with Resident #11 on 12/12/17 at 5:12 pm revealed she did not like lettuce and did not want the soup that was served. Interview with a PCA on 12/12/17 at 5:23 pm on revealed: -She had been working at the facility since August 2017She served residents in the dining hall during her shiftThe dietary staff told them what to serve to each	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		HAL013044	B. WING		12	2/14/2017
	ROVIDER OR SUPPLIER	160 WAI	ADDRESS, CITY, STATE RREN C. COLEMAN RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	and when she refuse meal." -Resident #11 always -She told dietary staft the MS diet when ser -"I didn't know I was served. RCC, or Administrate -She did not know if I been contacted regard physician ordered die Review of Resident # documentation Resident to the contacted regarding is as ordered. Review of the facility log on 12/13/17 reveals.	n a MS diet. put the meal in front of her s, we give her a regular s refused the MS diet. If that Resident #11 refused red to her. supposed to tell the MT, or." Resident #11's physician had rding her refusal to eat the et. It's record revealed no lent #11's physician was her refusing to eat a MS diet physician communication aled no documentation to the Resident #11 refusing to eat	D 273			
D 310	Service 10A NCAC 13F .0904 (e) Therapeutic Diet: (4) All therapeutic di supplements and thic	4(e)(4) Nutrition and Food 4 Nutrition and Food Service s in Adult Care Homes: ets, including nutritional ckened liquids, shall be the resident's physician.	D 310			
	reviews, the facility fa	ns, interviews, and record				

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		HAL013044	B. WING		12/1	4/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	IG CENTER OF CONCOR	RD	REN C. COLEM <i>i</i> D, NC 28027	AN BLVD.		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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D 310	Continued From page	≥ 30	D 310			
	for a Mechanical Soft ordered.	(MS) diet were served as				
	The findings are:					
	8/31/17 revealed: -Diagnoses included disorder, schizophrer regurgitation, and uns-There was a physicia diet. Review of the therape dietary manager date was to be served a receive of Resident # orders dated 12/7/17 regular MS diet.	eutic diet list provided by the ed 8/29/17 revealed resident egular MS diet. #11's 6 month physician's revealed an order for a				
	were to be served: -One piece of fried ch	ned potatoes with brown d vegetables. ell/bread. e. a ice cream.				
	MS diets to be served on 12/12/17 revealed be served: -One serving of grour	eutic diet spreadsheet for d for the lunch meal service I the following items were to and fried chicken. The potatoes with brown				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL013044	B. WING		12/1	4/2017
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	G CENTER OF CONCOR	RD.	EN C. COLEMA	AN BLVD.		
		CONCORD	NC 28027			
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D 310	Continued From page	31	D 310			
	-One serving of greer -One wheat dinner ro -One pat of margarine -One serving of vanill -A beverage of choice	ll/bread. e. a ice cream.				
	Observation of the lunch meal service on 12/12/17 at 11:00 am revealed: -Resident #11 was offered a meal consisting of ground fried chicken, mashed potatoes, brown gravy, green beans, a roll with margarine, vanilla ice cream and teaResident #11 said to staff, "What's that? I want what she has." -Resident #11 pointed to a regular plate with a grilled chicken breastStaff took the MS meal from Resident #11 and served her a regular meal consisting of a grilled chicken breast, mashed potatoes, brown gravy, mixed vegetables, a roll with margarine, vanilla ice cream and teaStaff offered to cut up Resident #11's chicken twice and Resident #11 said "no" twice to staff					
	cutting her meat upResident #11 ate about no difficulty with swall	out 50% of her meal and had owing or choking.				
	9:01 am revealed: -He and the dietary st contracted company a preparing and serving menusIt was the responsibility place food on resident the resident's diet order between the resident were listed serving line which list and their therapeutic	ed on a card behind the ed each resident's name				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/14/2017
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	12/14/2011
		160 WARRI	EN C. COLEMA		
THE LIVIN	IG CENTER OF CONCOR	RD CONCORD	, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 310	D 310 Continued From page 32 lineHe was aware Resident #11 had a physician's order for a MS dietResident #11 refused to eat a MS dietHe instructed staff to serve Resident #11 a MS diet and if she refused to then serve her a regular mealHe and dietary staff did not document when		D 310		
	Resident #11 refused to eat a MS dietIt was the responsibility of the facility staff to				
	document, notify the physician, and to ensure residents had appropriate diet orders.				
	-He had notified facility staff Resident #11 had been refusing her physician ordered MS diet.				
		menu for the dinner meal evealed the following items			
	-One serving of cabba -Two saltine crackers				
	 One deli sandwich w One serving of spring 	rith whole slices of meat. g mix with dressing.			
	-One serving of chille -A beverage of choice	d peaches.			
	Review of the therapeutic diet spreadsheet for MS diets to be served for the dinner meal service on 12/12/17 revealed the following items: were to be served: -One serving of cabbage and sausage soupTwo saltine crackersOne turkey salad sandwich.				
	_	dded lettuce with dressing. d peaches.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		HAL013044	B. WING		12	2/14/2017
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THE 1 15 // 16	10 OFNITED OF OONOO!	160 WAR	REN C. COLEMAN	I BLVD.		
THE LIVIN	IG CENTER OF CONCO	CONCOR	RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 310	Continued From page	e 33	D 310			
	salad sandwich)." -The dietary staff ser sandwich with whole tea.	nat there (pointing to a turkey ved Resident #11 a deli slices of meat, peaches, and wich was not offered to				
	Interview with Resident #11 on 12/12/17 at 5:12 pm revealed she did not like lettuce and did not want the soup that was served.					
	pm on revealed: -She had been worki 2017She served resident shiftThe dietary staff told residentResident #11 was or -"We're supposed to and when she refuse meal." -Resident #11 always -She told dietary staff MS diet when served -"I didn't know I was served -She did not know if I	put the meal in front of her es, we give her a regular so refused her MS diet. If Resident #11 refused her late to her. It to her. It is supposed to tell the MT, or." Resident #11's physician had refing her refusal to eat the				
	pm revealed: -She was not on a sp -She had not had a s told that she was on	wallowing test performed or a MS diet. 2/12/17 was the first time				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		' '	(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/1	4/2017
NAME OF PROVIDER OR SU	JPPLIER		DRESS, CITY, STA	TE, ZIP CODE	, , , , , , , ,	
THE LIVING CENTER O	E CONCOR	160 WARF	REN C. COLEM	AN BLVD.		
		CONCOR	D, NC 28027			
PREFIX (EACH	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 310 Continued	From page	e 34	D 310			
-"I thought in She did not swallowing -They gave -She would linterview with 12/12/17 at -She had with -She usuall during her she served prepared by -The dietang serving in the ordered means refused it to -She had to (MA) and the that Resided -She did not swallowing the swallowing in the ordered means refused it to -She had to (MA) and the that Resided -She did not swallowing the	it was a mot have any her food. her what I not eat he with a Person 2:56 pm roorked at the served rashift. #11 was or d meal tray the dieta y manager he dining he al in front to then give old the Adrine Residerent #11 had tot know if t	istake." y difficulties with eating or they served everyone else. er meats chopped. onal Care Aide (PCA) on evealed: ne facility for 3 weeks. neals in the dining hall a "chopped" diet. ys to Resident #11 that are				
(PA) on 12/ -Resident # -She was n -She had n	12/17 at 3 11 had and on the second of the	nt #11's Physician Assistant :52 pm revealed: order for a MS diet. niliar with Resident #11. tified Resident #11 had a MS diet and was eating a				
-The facility she was no -There was order was f -She expec a MS diet s	may have a may may may may may may may may may m	e notified the physician, but they had. In with aspirating if the diet notified if a resident refused order could be re-evaluated.				

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION		SURVEY
			A. BOILDING.			
		HAL013044	B. WING		12	/14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE LINUS	IC CENTED OF CONCOR	160 WARF	REN C. COLEMA	AN BLVD.		
I HE LIVIN	IG CENTER OF CONCOR	CONCOR	D, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 310	0 Continued From page 35		D 310			
<i>B</i> 510	at 4:07 pm revealed: -He was not aware R refusing to eat a MS of physicianThe Resident Care C responsible for contact physician to report the noncompliant with the -He was not aware if notified Resident #11 dietResident #11's physit notified Resident #11 diet and the resident -He was usually made during daily clinical st	esident #11 had been diet as ordered by the Coordinator (RCC) was cting the Resident #11's e resident had been e MS diet order. the physician had been was refusing to eat a MS cian should have been was refusing to eat a MS was eating a regular diet. e aware of clinical issues				
	Interview with the RCC on 12/12/17 at 4:15 pm revealed: -She had worked in her position since September 2017She was responsible for updating the therapeutic diet list and making sure the dietary staff was aware of any changes in diet ordersResident #11 was ordered a MS dietShe was not aware Resident #11 had been refusing to eat a MS diet and was being served a regular dietShe did not know if any other staff was aware Resident #11 was refusing to eat a MS dietWhen a resident refused to eat a physician ordered diet, the process was to make the physician aware and ask for recommendations from the physicianIt was her responsibility to notify the physician Resident #11 was not following the ordered dietShe did not contact the physician regarding					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/14	4/2017
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	IG CENTER OF CONCOR	RD	EN C. COLEMA , NC 28027	AN BLVD.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 310	Continued From page	e 36	D 310			
	aware Resident #11 v MS diet.	was not eating the ordered				
D 338	10A NCAC 13F .0909	Resident Rights	D 338			
	all residents guarante	shall assure that the rights of eed under G.S. 131D-21, ents' Rights, are maintained				
	This Rule is not met a					
	of 13 sampled resider #10, #11, #12, #13 ar abusive language, cu personal space in a h wrists of a resident wl insulin injections aggr as needed (PRN) me the floor unattended of other floors to get the	assing, violating a residents' mostile manner, holding both hile yelling, administering ressively, not administering dication to residents, leaving causing residents to go to eir medications, and Resident items (money and credit				
	The findings are:					
	Refer to TAG 914, G. Resident Rights (Type	S. 131D-21-4 Declaration of e A2 Violation).				
D 375	10A NCAC 13F .1005 Medications	5(a) Self-Administration Of	D 375			
	10A NCAC 13F .1005	5 Self -Administration Of				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/14/2017	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	12117/2011	
THE LIVIN	IG CENTER OF CONCOR	RD	REN C. COLEM D, NC 28027	AN BLVD.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
D 375	who are competent a self-administer their r requirements are met (1) the self-administra physician or other pe prescribe medications documented in the re (2) specific instruction	me shall permit residents nd physically able to medications if the following t: ation is ordered by a rson legally authorized to s in North Carolina and	D 375			
	This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to obtain a physician order for self-administration of medication for 3 of 9 sampled residents (Residents #2, #9, and #8) and assure the resident was physically able to self-administer medication.					
	The findings are:					
	A.Review of Resident #2's current FL-2 dated 3/7/17 revealed diagnoses included memory loss, hypertension, stroke, dyslipidemia.					
	-There was no order the Resident #2 to se medications. -There was a standin Imodium AD 2 mg (1) stool up to 8 doses in for persistent diarrhea	g order dated 6/20/17 for capsule with each loose 24 hours, notify physician				

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BOILDING			
		HAL013044	B. WING		12/1	4/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	NG CENTER OF CONCOR	160 WAR	REN C. COLEMA	AN BLVD.		
	- COLUTER OF CONCOR	CONCOR	RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 375	Continued From page	e 38	D 375			
	himself, purchased by sister-in-law. -He could not remem medications in his root. -His doctor did not pr medications and he control he was taking them. -He had Imodium in root help with diarrhea sincolon cancer. -He had a cream that help relieve pain wheten help and other help with help relieve pain wheten help relieve pain wheten help and a hother help and other help relieve staff took too long to	om that he administered to by his brother and aber how long he had these om. The secribe the OTC add not make her aware that the room that he administered to have he had recovered from the rubbed on his body to be needed. In medication he administered he had recovered from the rubbed on his body to be needed. In medication he administered he had recovered from the rubbed on his body to be needed. In medication he administered he had recovered by staff				
	medications removed by the facility reveale -The medications whi in the box included renumber written with a - A 4 ounce (oz.) tube (medication used to rpain)15 soft gel tablets of (medication used to tbloating)A 3 oz. tube of maxing cream (medication used to tbloating)100 ibuprofen tablets pain, reduce fever).	ich belonged to Resident #2 esident's name and room a permanent marker. e of ultra-strength muscle rub muscle aches and arthritis f 125 mg simethicone treat gas pain, pressure, and mum strength thera-gesic				

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control symptoms of diarrhea)

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/14/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		160 WARF	REN C. COLEMA			
THE LIVIN	G CENTER OF CONCOR	CONCOR	D, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 375	Continued From page	e 39	D 375			
	-1.76 oz. container of used as a cough suppanalgesic).	Vapor Rub (medication pressant and topical				
	revealed: -Some OTC medicati Resident #2 because medications at timesShe could not remen she purchased, howe Imodium for Resident complications with dia -She could not remen policy on self-adminis -Resident #2's physic of the OTC medicatio -She had not notified OTC medications for	P) on 12/12/17 at 9:25 am ons are purchased for staff are slow to administer when and exactly what ever remembered purchasing #2 to keep in room due to arrhea. wher if the facility had a stration. wian had not prescribed any was she purchased. staff that she purchased resident.				
	Review of Resident #2's medication administration record (MAR) for October, November, and December 2017 revealed there were no entries for any of the OTC medications Resident #2 reported he was taking.					
	#2 on 12/12/17 at 4:0 -She was not aware F self-administering OT -She had never comp Resident #2 to self-ac -If Resident #2 contin medication, he would imbalanceAll other OTC medic	Resident #2 was C medications. Deted an evaluation for dminister medications.				

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-She expected the facility to notify her so that she

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL013044	B. WING		12/14/2017	
NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCOR	160 WARF	DRESS, CITY, STA REN C. COLEMA D, NC 28027	,		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
of medicationShe had not been no facility that Resident # OTC medications. Interview with pharma 12/13/17 at 11:12 am -Prescriptions orders of from the facility or the -Resident #2 never had thera-gesic, ibuprofen simethicone to be fille -OTC medications are pharmacy. Interview with a Medications are pharmacy. Interview with a Medications are pharmacy. Interview with a Medications are pharmacy. -She had never seen Resident #2's roomShe was not aware the administering his own -She administers Resilisted on the MARShe never checked Formedications. Interview with the Resident Mark -She reviewed all medications. Interview with the Resident #2 to self-administration of the sel	dent for self-administration tified by anyone at the #2 was self-administering acy representative on revealed: were received electronically physician. ad an order Imodium, representative or ad an order Imodium, representative on revealed: any order Imodium, representative on revealed: any order Imodium, representative on revealed rub, or d. representative on revealed: representative on revealed rub, or d. representative on revealed: representative on revealed rub, or representative on revealed: representative on revealed rub, or representative on revealed: representative on revealed rub, or representative on revealed rub, or representative on revealed rub, or representative on revealed: representations represent	D 375			

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-She was not aware Resident #2 was

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12	2/14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	·	
		160 WAR	REN C. COLEMAN			
THE LIVIN	IG CENTER OF CONCOR	RD CONCOR	RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 375	Continued From page self-administering me		D 375			
	- She was not aware confiscated from Resinad not notified the pl	of medications being ident #2 room therefore she				
	Interview with the Administrator on 12/13/17 at 11:35 am revealed: -The facility had a policy on file regarding the management of resident self-administration of medications. -A doctor's order for self-administration must be obtained for all medications administered by the resident. -Resident #2 did not have an order to					
	self-administer medic -He was not aware th medications in their ro medications from root	ations. at Resident #2 had OTC oom, until a PCA removed m.				
	doctor of self-adminis -He was unsure if the	onsible for notifying the tration of medications. doctor or family had been dent #2 was administering				
	-Residents and familie admission that the res	e removed from his room. es were notified during sident must give RCC to be administered				
	-Residents must be e	istered without an order. valuated by facility RCC and ninistering medications.				
	6/12/17 revealed diag diabetes, hypertensio	nt #9's current FL-2 dated gnoses included type 2 n, hyperlipidemia, anemia, se, and history of transient				
	Review of the Reside	nt #9's record revealed:				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 375 Continued From page 42 -There was no order or evaluation completed for the Resident #9 to self-administer his medications. -There was a standing order dated 6/20/17 for Tylenol 500 mg 2 tablets every 6 hours as needed for 24 hours, notify physician if fever lasts longer	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
THE LIVING CENTER OF CONCORD CONCORD, NC 28027 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 375 Continued From page 42 -There was no order or evaluation completed for the Resident #9 to self-administer his medications. -There was a standing order dated 6/20/17 for Tylenol 500 mg 2 tablets every 6 hours as needed for 24 hours, notify physician if fever lasts longer		HAL013044	B. WING		12/14/201	17	
CONCORD, NC 28027 (X4) ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 375 Continued From page 42 -There was no order or evaluation completed for the Resident #9 to self-administer his medicationsThere was a standing order dated 6/20/17 for Tylenol 500 mg 2 tablets every 6 hours as needed for 24 hours, notify physician if fever lasts longer	NAME OF PROVIDER OR SUPPLIER	ER STREET AD	DRESS, CITY, STATE	E, ZIP CODE	•		
CONCORD, NC 28027 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 375 Continued From page 42 -There was no order or evaluation completed for the Resident #9 to self-administer his medications. -There was a standing order dated 6/20/17 for Tylenol 500 mg 2 tablets every 6 hours as needed for 24 hours, notify physician if fever lasts longer	THE LIVING OFFITED OF COMO	160 WAR	REN C. COLEMAI	N BLVD.			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 375 Continued From page 42 -There was no order or evaluation completed for the Resident #9 to self-administer his medications. -There was a standing order dated 6/20/17 for Tylenol 500 mg 2 tablets every 6 hours as needed for 24 hours, notify physician if fever lasts longer	THE LIVING CENTER OF CONCO	CONCOR	D, NC 28027				
-There was no order or evaluation completed for the Resident #9 to self-administer his medicationsThere was a standing order dated 6/20/17 for Tylenol 500 mg 2 tablets every 6 hours as needed for 24 hours, notify physician if fever lasts longer	PREFIX (EACH DEFICIENC	FICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	D BE COM	MPLETE	
the Resident #9 to self-administer his medicationsThere was a standing order dated 6/20/17 for Tylenol 500 mg 2 tablets every 6 hours as needed for 24 hours, notify physician if fever lasts longer	D 375 Continued From pag	n page 42	D 375				
Interview with Resident #9 on 12/12/17 at 6:00 pm revealed: -He had OTC medications in his room that he administered to himselfHe had several medications that included a cough medicine and Tylenol that he used when he needed He could not remember exactly how many medications he had in his roomThe medications were removed at 2:00 am on 12/11/17 by 3 staff membersHe could not remember how long he had these medications in his room He administered the OTC medication whenever he felt that he needed it The OTC medication was purchased by his daughter He thought he was capable of administering his own medications as he administered when he lived at home. Observations on 12/13/17 at 11:00 am of a box of medications removed from the resident's rooms by the facility revealed: - The medications which belonged to Resident #9 in the box included resident's name and room number written with a permanent marker A 1.5 oz. bottle of saline nasal spray (medication used to moisturize nasal passages) A 1 bottle of 100 tablets of extra strength 500 mg	-There was no order the Resident #9 to se medicationsThere was a standir Tylenol 500 mg 2 tab for 24 hours, notify p than 24 hours. Interview with Resid pm revealed: -He had OTC medica administered to hims -He had several medications and he needed He could not remer medications he had in -The medications were 12/11/17 by 3 staff moder -He could not remer medications in his roughled in the felt that he needed -The OTC medications daughter He thought he was own medications as lived at home. Observations on 12/12 medications which is the positions of the medications which is the box included results of the positions of the positions of the positions of the positions which is the box included results of the positions of the positions of the positions which is the positions of the positio	order or evaluation completed for 9 to self-administer his tanding order dated 6/20/17 for 12 tablets every 6 hours as needed of of the physician if fever lasts longer Resident #9 on 12/12/17 at 6:00 medications in his room that he of himself. all medications that included a er and Tylenol that he used when remember exactly how many had in his room. In swere removed at 2:00 am on staff members. The emember how long he had these his room. The ed the OTC medication whenever needed it. The ication was purchased by his The was capable of administering his has as he administered when he The 12/13/17 at 11:00 am of a box of moved from the resident's rooms evealed: The instance of the permanent marker. The of saline nasal spray (medication rize nasal passages).					

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-A 1.5 oz. of premium saline nasal spray

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/1	4/2017
	ROVIDER OR SUPPLIER	160 WARRI	RESS, CITY, STA En C. Colema , NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 375	-14 tablets of 1200 m dextromethorphan (A control cough) -3 Salonpas Gel Pato capsaicin and 1.25% to relieve pain)0.33 oz. bottle of hor (medication used to re-A 4.7 oz. tube of Aspirolamine salicylate (repain)1 Icy-Hot patch medi (medication used to re-100 ibuprofen tablets pain, reduce fever)1.76 oz. container of as a cough suppressa-20 tablets of 125 mg used to treat gas pain. Telephone interview w Responsible Party (R revealed: - OTC medications ar #9 because she felt Fadministering his own-She purchased OTC #9 and did not notify sin the roomShe could not remenshe purchasedShe could not remenshe purchasedShe could not remenshe purchasedShe could not remenshe policy on self-adminis-Resident #9's physic of the OTC medication.	oothe dry nasal passages). g guifenesin and 60 mg lso called Mucinex used to hes containing 0.025% menthol (medication used meopathic ear ache drops elieve ear discomfort). Percreme containing 10% medication used to treat medication used to treat medication used to relieve vapor rub (medication used ant and topical analgesic). Simethicone (medication used ant and topical analgesic) with Resident #9's P) on 12/13/17 at 11:36 am medications. The purchased for Resident and the purchased for Resident staff that medications were suber when and exactly what the purchased.	D 375			

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were no entries for any of the OTC medications

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/14/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	IG CENTER OF CONCOR	RD	EN C. COLEMA	AN BLVD.		
), NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE	
D 375	Continued From page 44		D 375			
	Resident #9 reported he was taking.					
	primary care physicia - The primary care ph aware that resident w medicationsPCP felt that Reside administering his med - PCP did not recall of self-administration for medicationsPCP had not been not resident had been ad -PCP expected to be medications or reque Attempted interview w on 12/13/17 at 11:35 Interview with a Med 12/12/17 at 3:45 pm or -She had never seen Resident #9's roomShe was not aware to administering his owor -She administers Resilisted on the MARShe never checked of medications. Interview with the Resilisted on 12/12/17 at -She reviewed all me -She would perform as self-administration of -She had not complete Resident #9 to self-administration -She had not complete Resident #9 to self-administration of -She had not complete	aysician (PCP) was not as self-administering OTC Int #9 was capable of dications. In for resident to administer of the dications of the facility that ministering medications. In the facility that ministering medications in the facility that ministering medications in the facility of the facility that ministering medications as the facility of the fac				

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STATE FORM 6899 Y1H911 If continuation sheet 45 of 71

STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		1101.042044	B. WING		40/44/0047
		HAL013044			12/14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
THE LIVIN	IC CENTED OF CONCO	160 WARI	REN C. COLEM	AN BLVD.	
I HE LIVIN	IG CENTER OF CONCO	CONCOR	D, NC 28027		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE
				BEI IGIERGI)	
D 375	Continued From page	e 45	D 375		
		ician every 6 months.			
	-MA's were responsit				
	Resident #9 medicati				
	-She was not aware				
	self-administering me				
	- She was not aware	•			
		sident #9 room therefore she			
	had not notified the p				
	-She was responsible for verification of orders for self-administration.				
	Intomious sith the Ad				
		ministrator on 12/13/17 at			
	11:35 am revealed:	liev on file we would be the			
		licy on file regarding the			
		lent self-administration of			
	medications.	alf administration moved by			
		self-administration must be			
	resident.	cations administered by the			
	-Resident #9 did not	have an order to			
	self-administer medic				
		nat Resident #9 had OTC			
		oom, until a PCA removed			
	medications from roo				
		onsible for notifying the			
	l	stration of medications.			
		e doctor or family had been			
		dent #9 was administering			
		e removed from his room.			
		ies were notified during			
	admission that the re				
		RCC to be administered			
		istered without an order.			
		evaluated by facility RCC and			
		ministering medications.			
	priyaidian pridi to adi	minatering medications.			
	C. Review of Resider	nt #8's FI 2 revealed:			
		dementia, depression, atrial			
		nd coronary artery disease.			

Division of Health Service Regulation

-There were no medication orders for lubricant

STATE FORM 9899 Y1H911 If continuation sheet 46 of 71

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED
		HAI 042044	B. WING		4.	0/4.4/0047
		HAL013044			12	2/14/2017
NAME OF PR	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
THE LIVIN	NG CENTER OF CONCO	RD	RREN C. COLEMAN	I BLVD.		
		CONCO	RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 375	Continued From page	e 46	D 375			
	eye drops, triple antit wipes, or mentholatu	piotic ointment, antiseptic m ointment.				
	solution 1.4 %, instill times daily as needed minutes between diffication. There was no order medication. There was no docum assessment for self-at Review of Resident # orders dated 6/26/17 There was an order order for the resident artificial tears. There was no order antiseptic wipes, or not the resident artificial tears.	an's order for artificial tears one drop in both eyes four d for dry eyes (wait 3-5 erent eye drops). to self-administration of metation of a cognitive administration of medication. #8's 6 month physician revealed: for artificial tears and an to self-administer the for triple antibiotic ointment, mentholatum ointment.				
	Review of Resident # Administration Recor November, and Dece -An entry for artificial drop in both eyes fou -There were no entrie ointment, antiseptic v ointment. Interview with Reside am revealed: -"Somebody came in drops." -"I looked for my eye them. I don't know with	d (MAR) for October, ember 2017 revealed: tears solution 1.4%, instill 1 or times daily as needed. es for triple antibiotic vipes, or mentholatum ent #8 on 12/13/17 at 9:05 my room and stole my eye drops and couldn't find no took them."				
	-There was no order antiseptic wipes, or nother was no order other medication. Review of Resident *Administration Record November, and Decelor -An entry for artificial drop in both eyes four -There were no entries ointment, antiseptic word ointment. Interview with Reside am revealed: -"Somebody came in drops." -"I looked for my eye them. I don't know with the same and the same	tears solution 1.4%, instill 1 in times daily as needed. es for triple antibiotic vipes, or mentholatum ent #8 on 12/13/17 at 9:05 my room and stole my eye drops and couldn't find no took them." ther self-administration of any ent #8 on 12/13/17 at 9:05				

Division of Health Service Regulation

STATE FORM 9899 Y1H911 If continuation sheet 47 of 71

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		HAL013044	B. WING		12/1	4/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE ! 10 (15)		160 WAR	REN C. COLEMA	AN BLVD.		
THE LIVIN	IG CENTER OF CONCOR	CONCOR	D, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 375	Continued From page	e 47	D 375			
	room.	another resident came in her me drops in their eyes if they				
	at 9:29 am revealed: -He had a Medication over-the-counter (OT resident's room after facility staff in a reside -He was not aware R medication in her roo -He was not aware R complaining about ha out of her roomHe assumed Reside brought the medicatio -He did not know if R self-administer medic -He did not know if R assessment complete capable of self-admin	esident #8 had been aving her eye drops taken nt #8's family members on into the facility for her. esident #8 had an order to				
	admission that any O given to the MA. -The Resident Care O responsible for ensur self-administer medic residents who kept O -The RCC was in the residents' physicians who had been taking facility staff found in to Observations on 12/1 medications confiscar facility revealed:	Coordinator (RCC) was ing a physician's order to eation was in place for TC medication in their room. process of contacting the to notify them of residents OTC medications that				

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tears lubricant eye drops (used to treat dry eyes)

STATE FORM 6899 Y1H911 If continuation sheet 48 of 71

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		HAL013044	B. WING		12/1	4/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	G CENTER OF CONCOR	RD	REN C. COLEM	AN BLVD.		
		CONCOR	D, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 375	Continued From page	e 48	D 375			
D 3/5	in the original packag and room number writer was a 1 ounce on ointment (used to predict the resident #8's name at it. There was 1 count produced to prevent infections) and room number writer two 1 ounce of ointment (used to relipain) with Resident #written on them. Second interview with 10:16 revealed: "I'm supposed to take day." The eye drops were of her bedside table. "I'didn't give the eye them." -Resident #8 did not lead of the drops. "I'did have a good bit and got it all out." -She called her family someone took her eyencesident #8's family staff. -She did not know if the order for the resident medication. Interview with a MA of the source was a support of the resident medication.	ging with Resident #8's name itten on it. The tube of triple antibiotic event infections) with and room number written on the ack of first aide wipes (used with Resident #8's name itten on it. The containers of mentholatum eve minor muscle and joint iteles name and room number in Resident #8 on 12/13/17 at the ethe eye drops 3 times a covered up in the top drawer drops to anyone. They took know who took her eye it of medicine, but they came and told her that	D 3/5			
	revealed -She was not aware i medication in her roo -She was not aware i					

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self-administering any medications or had a

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S		
			A. BOILDING.			
		HAL013044	B. WING		12/1	14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	IG CENTER OF CONCOR	RD	EN C. COLEMA), NC 28027	AN BLVD.		
04.0.15	CLIMMADV CT		·	DDOVIDEDIS DI AN OF CODDECT	ION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 375	Continued From page	e 49	D 375			
	-Resident #8 had to h medication to be kept -It was the RCC's res physician's order to s	elf-administer medication. lave a physician's order for in her room. ponsibility to ensure a elf-administer medication DTC medications kept in a				
	Interview with a family member of Resident #8 on 12/13/17 at 10:23 am revealed -She received a call from Resident #8 stating that someone stole her eye dropsShe had purchased the eye drops and other medications for Resident #8 to keep in her roomResident #8 had a "note" from her doctor stating she could keep her eye drops in her roomShe did not inform the staff she had brought in the other OTC medications for Resident #8She was not aware Resident #8 needed a physician's order for OTC medicationsFacility staff had confiscated Resident #8's OTC medication in the past.					
	Attempted telephone physician on 12/13/17 unsuccessful.	interview with Resident #8's 7 at 11:15 am was				
	pm revealed: -She was not aware for medications in her row she was not aware in physician's order to self OTC medications who was not make the medications and medications who was not aware for medications in her row should be a supply so that the medications who was not aware for medications in her row should be a supply so that the medications who was not aware in physician's order to self-the medications who was not aware in physician's order to self-the medications who was not aware in physician's order to self-the medications who was not aware in physician's order to self-the medications who was not aware in physician's order to self-the medications who was not aware in physician's order to self-the medications who was not aware in physician who was no	om. f Resident #8 had a elf-administer medication. were found in a resident's would take the medications				
	Interview with the RC revealed:	C on 12/13/17 at 2:36 pm				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL013044	B. WING		12/14/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE LIVIN	C CENTED OF CONCOR	160 WARR	EN C. COLEMA	AN BLVD.	
THE LIVIN	G CENTER OF CONCOR	CONCORD	, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 375	75 Continued From page 50		D 375		
D 3/5	-She was not aware is medications in her roo- She was not aware is physician's order to sif a cognitive assessing Resident #8 to be able medicationShe was responsible orders for self-adminited and for ensurement was completed every self-administered means as completed every self-administered means. She had not contacted to obtain an order to shad a cognitive assessing the physician was not self-administering means. The physician was not self-administering means and the physician was not self-administering means. The physician was not self-administer in the facility did not as #8 to self-administer in the facility would here.	Resident #8 had OTC om. f Resident #8 had a elf-administer medication or nent had been completed for e to safely self-administer for ensuring physician stration of medication were uring a cognitive assessment 6 months for residents who dication. ed Resident #8's physician self-administer medication or sment completed for her. with a representative from an's office on 12/14/17 at ot aware Resident #8 was dication. ot written an order for dminister medication. ot aware Resident #8 elf-administer medication sk for an order for Resident medication she kept in her ave asked for an order to edication that Resident #8	D 375		
D 438	10A NCAC 13F .1205 Registry	6 Health Care Personnel	D 438		
	10A NCAC 13F .1205 Registry	Health Care Personnel			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE S COMPL		
		HAL013044	B. WING		12/1	4/2017
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	E, ZIP CODE	-	
		160 WAF	REN C. COLEMA	AN BLVD.		
THE LIVIN	IG CENTER OF CONCOR	CONCO	RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 438	Continued From page	e 51	D 438			
		oly with G.S. 131E-256 and NCAC 13O .0101 and				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	facility failed assure s verbal and mental ab Health Care Personn to 1 sampled staff (St	ews and interviews, the suspected allegations of use were reported to the el Registry (HCPR) related raff B) a Medication Aide lly and abusively mistreating				
	The findings are:					
	accused me of saying -Three residents said medications to themOne resident said St ask for an as needed -One residents said " other floors had giver "does not have to dea -Staff B refused to giv her "I was calling the decided to give me m -Other MAs administe Staff B "does not war me."	aff B was "very mean to me, g things I did not say." Staff B did not administer aff B "got an attitude" when I (PRN) medication. Medication Aide (MA) from a medications, so Staff B al with me." If we my medications so I told police, after that she by medications." Bered medications because at to help me or deal with				
		have seen Staff B have an mate over her medications".				

Division of Health Service Regulation

STATE FORM 9899 Y1H911 If continuation sheet 52 of 71

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		
		HAL013044	B. WING		12/14/2017
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE LIVING CENTER OF CONCORD			EN C. COLEMA	AN BLVD.	
1112 214114	- COLITIZATION CONTROL	CONCORD	, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 438	Continued From page	e 52	D 438		
D 438	-One resident said "I I do not want Staff B in the ask for my medication -Staff B was not approher way and do not at -When Staff B worked the floor when I need -Staff B would leave the at a time leaving the rewhen Staff B adminiarm"Staff B had gotten "ir and kept yelling at me jail""I refused medication [Staff B] always compand." -"I feel like Staff B trieme, getting in my face my medications." -Other facility staff we and verbally abuse to -"I have gone to the Amy concerns to him, be "I do not feel safe as Staff B is working." Confidential interviewelnitially, they were af Resident Care Coord family member and Sworked in the facility and -They were afraid of grace RCC was Staff B is and arguments."	stay out of her way because to be ugly to me". e hallway cussing so I do not his." coachable "so I stay out of sk for help". d "I could not find anyone on eed my medications or help". o smoke for 20-30 minutes residents unattended. stered insulin she "hurts my my face on one occasion e, hit me and you will go to his and insulin shots because plained and tried to get me est to provoke me by cussing e, and refusing to give me ere aware Staff B was mean residents. Idministrator and reported but nothing has been done." king for medications when with multiple staff revealed: raid to talk because the inator (RCC) was Staff B's taff B's other family member as well. getting fired because the mily member. ked to residents "smart gued with residents, and said	D 438		
	-	ed Staff B hit residents, but dents did not like the way			

Division of Health Service Regulation

STATE FORM 6899 Y1H911 If continuation sheet 53 of 71

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		
		HAL013044	B. WING		12/14/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		160 WARRI	EN C. COLEMA	AN BLVD.	
THE LIVIN	G CENTER OF CONCOR	CONCORD	, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 438	Continued From page	e 53	D 438		
	Staff B treated themStaff B had been rep Administrator in April resident's face while I down on the walker." -In April 2017 Staff B from the resident and law on the residentStaff B was suspend returned to workStaff B would cuss re down to residents she floorResidents would go medications administed months ago Staff B he administered insulinStaff were sure the A Staff B's attitude towa	ported to the previous 2017 for "getting in a holding the resident wrists had to be separated by staff had threatened to call the ed for a few days and then esidents and would talk did not like on the third to other floors to have their ered. hined to a staff person a few furth his arm when she administrator was aware of ard residents because Staff en going on since April 2017			
	Staff B revealed: -Documented April 20 counseled by a former making disrespectful Staff B had received a resident rights, rando interviews were condimanagement in Octol Residents had not discomments about Staff-Documentation in No.	er Administrator in regards to comments to residents, additional training on m unannounced resident ucted by facility ber and November 2017, sclosed any negative			
	regards to her frustrat were demanding med medication pass, inte	tions with residents who			

Division of Health Service Regulation

STATE FORM 9899 Y1H911 If continuation sheet 54 of 71

HAL013044 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X6)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
THE LIVING CENTER OF CONCORD 160 WARREN C. COLEMAN BLVD. CONCORD, NC 28027			HAL013044	B. WING		12/14/20	017
THE LIVING CENTER OF CONCORD CONCORD, NC 28027	NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
CONCORD, NC 28027			160 WARRI	EN C. COLEMA	AN BLVD.		
(VALID SLIMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	THE LIVING	G CENTER OF CONCOR	CONCORD	, NC 28027			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP.		(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPE	BE CC	(X5) OMPLETE DATE
D 438 away and asking for assistance during the medication pass, residents' behaviors did not justify Staff B's actions of responding disrespectful back to them, Staff B would be monitored closely and mamangment would discuss with Human Resources (HR) further action if continued behaviors. -There was no documentation the allegations in April 2017 or November 2017 in regards to Staff B had been reported to the Health Care Personnel Registry (HCPR) within 24 hours of knowledge of the events and an investigation completed within 5 day report to the HCPR. Telephone interview with the HCPR on 12/13/17 at 12:30 pm revealed they had not received a 24 hour report or 5 day investigation from the facility regarding Staff B, as of yet. Interview on 12/13/17 with Staff B at 2:16 pm revealed: -The Administrator and the Regional Director were present during the interview. -Staff B was the Medication Aide (MA) for the 3rd floor and worked 2nd shift. -She dispensed all medications for the residents on the 3rd floor. -She was hired on 04/12/16. -She was hired on 04/12/16. -She was hired on 04/12/16. -She was unaware multiple residents and multiple staff had complained about her behaviors and attitude. -In April 2017, she alleged a resident on the third floor assaulted her with his walker: -There were other staff present during the altercation. -She was suspended for a week, put on probation for 30 days and in "jeopardy of losing her job". -I about lost my job over it in April 2017.* -In November 2017 a resident 'got in my face and	a r j j c c r c c c c c c c c c c c c c c	away and asking for a medication pass, resi justify Staff B's action disrespectful back to monitored closely and discuss with Human Faction if continued be There was no docum April 2017 or Novemb B had been reported Personnel Registry (Fknowledge of the eve completed within 5 da Telephone interview wat 12:30 pm revealed hour report or 5 day in regarding Staff B, as Interview on 12/13/17 revealed: The Administrator and were present during the Staff B was the Medi floor and worked 2nd She dispensed all moon the 3rd floor. She was hired on 04-She was unaware mon staff had complained attitude. In April 2017, she allefloor assaulted her with There were other staff lercation. She was suspended for 30 days and in "jest" about lost my job of the staff of the staff loot as suspended for 30 days and in "jest" about lost my job of the staff loot and lost my job of the staff loot and lost my job of the staff lercation.	assistance during the dents' behaviors did not s of responding them, Staff B would be d mamangment would Resources (HR) further haviors. Inentation the allegations in per 2017 in regards to Staff to the Health Care HCPR) within 24 hours of ints and an investigation by report to the HCPR. With the HCPR on 12/13/17 they had not received a 24 investigation from the facility of yet. With Staff B at 2:16 pm and the Regional Director he interview. Cation Aide (MA) for the 3rd shift. Redications for the residents With Staff B at 2:16 pm and the Regional Director he interview. Cation Aide (MA) for the 3rd shift. Redications for the residents With Staff B at 2:16 pm and the shift. Redications for the residents With Staff B at 2:16 pm and the shift. Redications for the residents With Staff B at 2:16 pm and the shift. Redications for the residents With Staff B at 2:16 pm and the shift. Redications for the residents With Staff B at 2:16 pm and the shift. Redications for the residents With Staff B at 2:16 pm and the shift. Redications for the residents With Staff B at 2:16 pm and the shift. Redications for the residents With Staff B at 2:16 pm and the shift. Redications for the residents With Staff B at 2:16 pm and the shift. Redications for the residents With Staff B at 2:16 pm and the shift. Redications for the residents With Staff B at 2:16 pm and the shift.	D 438			

Division of Health Service Regulation

STATE FORM 6899 Y1H911 If continuation sheet 55 of 71

DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL013044	B. WING		12/14/2017
		HAL013044			12/14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
160 WARF			EN C. COLEM	AN BLVD.	
THE LIVING CENTER OF CONCORD CONCORD			D, NC 28027		
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	J (V5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 438	Continued From page	55	D 438		
2 .00					
		the Administrator's office			
	was given verbal war	_			
	•	ive her instructions to report			
		ident to him because the			
	RCC was a family me				
		like the way an insulin pen			
		the insulin" theycomplained			
		isor, "I started using a			
	regular insulin syringe				
	•	y a hand on a resident", she			
	"would hug them".				
	_	d so does everyone else, so I			
		the time, that's just life."			
		ted the supervisor when she			
		een in a resident's room for			
	an extended period of				
		ld be in a resident's room for			
		sonal care, "maybe that's			
		ot find me on the floor."			
		side (PCA) would cover the			
	15 or 20 minutes.	o smoke or left the floor for			
		lanta had gone to other			
	floors to get the MAs	lents had gone to other			
	-	she was off of the floor.			
	-She did not cuss in fi				
		ly residents or staff would			
	say anything about he	· -			
		eat all of the residents the			
		ecause of how they treat			
	me."	course of field aloy from			
		of why she was called into			
		7) until the Administrator			
	· ·	sations from the staff and			
	residents about her b				
		uage, getting in resident's			
	face, painful injections				
		ole to located when needed,			
	and "laying hands on				

Division of Health Service Regulation

-She was unaware what a Health Care Personnel

STATE FORM 9899 Y1H911 If continuation sheet 56 of 71

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			5 14/11/0		
		HAL013044	B. WING		12/14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
THE LIVING CENTER OF CONCORD 160 WARI			REN C. COLEM	AN BLVD.	
I HE LIVIN	IG CENTER OF CONCOR	CONCOR	D, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 438	Continued From page	e 56	D 438		
	• • • • • • • • • • • • • • • • • • • •	s or if the facility had reported ons to the HCPR in April 2017			
	with the Administrator -He took over as Adm	7 at 2:30 pm and at 3:06 pm r revealed: ninistrator 6 months ago.			
	April 2017 in regards the third floor.	to Staff B and a resident on			
	-The report in April 2017 was initiated by the previous Administrator.				
	then returned to work	spended in April 2017, and			
		rted to the HCPR at that			
		cident report in November			
	2017 in regards to Statement frustration with reside pass.	aff B behaviors and ents during the medication			
	•	al warning to Staff B in			
	Staff B in November 2				
	neglect were to be re	Illegations of abuse or ported to the HCPR within			
	24 hours and a 5 day -He did not know mul	investigation was to occur.			
		aff B in regards to verbally			
	•	issing, violating a residents'			
		nostile manner, holding both			
		ile yelling, administering			
	medication aggressiv				
	-	stering as needed (PRN)			
		nts, and leaving the floor residents to go to other floors			
	to get there medication				
	_	B's family member was the			
		to the RCC except Staff B,			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL013044	B. WING		12/14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
THE LIVING CENTER OF CONCORD 160 WARF			EN C. COLEMA	AN BLVD.	
		CONCOR), NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 438	Continued From page 57		D 438		
	had given during the -There was as supervillations should never be -It was Staff B's respo to contact the supervillation-He had suspended Simulations -He would report the	some of the details Staff B interview until 12/13/17. visor on 2nd shift and the eleft unattended. onsibility if she left the floor sor to cover the floor. Staff B on 12/13/17. allegations to the HCPR on the a 5 day investigation in			
	The facility failed to report suspected resident abuse related to alleged staff (Staff B) being verbally and mentally abusive, cussing residents, violating a residents' personal space in a hostile manner, holding both wrist of a resident while yelling, administering insulin aggressively, and leaving the floor unattended on several occasions. The failure to report Staff B to the HCPR within 24 hours of knowledge of the events in April 2017 and November 2017 was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation.				
	allegations of residen exploration to the HC -The Administrator wi investigation on all th-Immediately, the acc suspended pending the investigationThe Administrator wi and staff interviews to	7: ministrator will report the t abuse, neglect or PR. Il begin an internal e allegations of abuse. sused (Staff B) will be			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL013044	B. WING		12/14/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE LIVIN	IC CENTED OF CONCOR	160 WARR	EN C. COLEMA	AN BLVD.	
I HE LIVIN	IG CENTER OF CONCOR	CONCORD	, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 438	Continued From page 58		D 438		
	-The Regional Director department will conduinterviews and staff in rights are not being vithen randomly thereat CORRECTION DATE	nterviews to ensure resident iolated, monthly times 4 and fter.			
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.		D911		
	Individuality and right to privacy. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to treat residents with respect, dignity and full recognition of his or her individuality and the right to privacy in their room while sleeping and removing OTC medications without proper explanation for 2 of 9 sampled residents (Resident #2 and #9).				
	The findings are:				
	am revealed: -He had some over-the medications in his root himself, purchased by sister-in-lawHe had OTC medical	om that he administered to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/14	1/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-	
THE LIVING CENTER OF CONCORD 160 WAR			REN C. COLEMA	AN BLVD.		
	- COLUMN CONTROL	CONCOR	D, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D911	Continued From page	e 59	D911			
וופּט	-The medications had during the evening or -He remembered "thr room to take medicat took them"He felt "upset" that toof the night" to take it -He did not understar to be taken out of the sleeping". Telephone interview or Responsible Party (Rome taken out of the sleeping". Telephone interview or Responsible Party (Rome taken by staffShe was not aware to were taken by staffShe was "not please taken out of the room -She felt "someone or that this was going to the lad otto medical administered to himself had otto medical medicine and the needed.	d been removed by staff in 12/11/17. ee nurses coming in the ions, they did not ask, they he staff came "in the middle ems that belonged to him". Ind why the medications had room "late at night while with Resident #2 P) on 12/12/17 at 9:25 am hat the resident's medication d with how medication were " ould have called to notify take place". Int #9 on 12/12/17 at 6:00 tions in his room that he	Dall			
	12/11/17 by 3 staff m -He was "mad" that s woke him up from sle his family member br - He was "confused" understand why staff night.	re removed at 2:00 am on embers. taff removed items and eping to take medications				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/1	4/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	IG CENTER OF CONCOR	RD	REN C. COLEMA	AN BLVD.		
		CONCOR	D, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D911	Continued From page	e 60	D911			
	revealed: - OTC medications an #9 because she felt the of administering his or- She was not notified to be removed from re- She called and spok facility who explained removed She was "not please interrupted to remove Observations on 12/1 medications removed facility revealed: - Medications from Re All medications that Resident #9 in the boo	re purchased for Resident hat resident #9 was capable own medications. I that medications were going residents' room. It with someone at the di why medications were with someone at the medications were red with how his sleep was a medications". It was a substitution of the medication of the medicat				
	Interview with Personal Care Assistant (PCA) on 12/13/17 at 10:58 am revealed: -She normally worked as a 2nd shift PCAShe worked until 2 am on 12/11/17She received instruction from the Administrator to check Resident #2's and Resident #9's room for any medications for residents who did not have an order to self-administer medicationsShe knew the few residents in the facility who had an order to self-administer medicationsShe removed OTC medications from Resident #2's and #9's room in the evening on 12/11/2017She could not remember what time she went in the rooms to remove medicationsShe asked residents if she could remove the medications before taking them.					

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-The Administrator instructed her, if residents

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12	2/14/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE	•		
IVANIE OF T	NOVIDEN ON OUT FIEN		RREN C. COLEMAN				
THE LIVIN	IG CENTER OF CONCO	RD	RD, NC 28027	. 52.5.			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D911	Continued From pag	e 61	D911				
	familyNo resident refused their roomAfter removing medioffice for the Adminis	to give medications found in ications, she left them in the strator to review.					
	-Another resident in the medications in the rowith each resident to medication they may -He instructed a 2nd in the building to ask who did not have an -He was not aware the OTC medications in the medications -He had not had a chaprocess to obtain OT residentsHe instructed the PC	om and he wanted to check see if they had any OTC had been self-administering. shift PCA to go to all rooms for medications of residents order to self-administer. nat Resident #2 and #9 had their room, until a PCA is from room.					
D912	G.S. 131D-21 Decla Every resident shall I 2. To receive care a adequate, appropriat	claration of Residents' Rights ration of Residents' Rights have the following rights: nd services which are i.e., and in compliance with state laws and rules and	D912				
	This Rule is not met Based on record revi	as evidenced by: ew and interviews, the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		HAL013044	B. WING		12/1	14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	IG CENTER OF CONCOR	RD	REN C. COLEMA	AN BLVD.		
		CONCOR	D, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D912	Continued From page	e 62	D912			
	right to receive care a adequate, appropriate relevant federal and s regulations as related	e every resident had the and services which are e, and in compliance with state laws and rules and I to other staff qualifications, I registry, and residents				
	The findings are:					
	reviews, the facility fa sampled staff (Staff E substantiated findings Health Care Personn	and Staff D) had no s on the North Carolina el Registry (HCPR).[Refer to 13F.0407(a) (5) Other Staff				
	facility failed assure a mental abuse were re Personnel Registry (H staff (Staff B) a Medic mentally and abusive	eviews and interviews, the allegations of verbal and eported to the Health Care HCPR) related to 1 sampled cation Aide (MA) who was ly mistreating multiple g 438, 10A NCAC 13F.1205 el Registry (Type B				
	protect multiple reside language, cussing, vi space in a hostile ma a resident while yellin injections aggressive needed (PRN) medic the floor unattended other floors to get the resident who had per credit card) stolen fro	vs, the facility failed to ents from verbally abusive olating a residents' personal nner, holding both wrists of ag, administering insulin ly, not administering as ation to residents, leaving causing residents to go to air medications, and a sonal items (money and m a lockable space.[Refer				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		' '	(X3) DATE SURVEY COMPLETED	
		HAL013044	B. WING		12/14/2	2047
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	1 12/14/2	2017
		160 WARRI	EN C. COLEMA			
I HE LIVIN	G CENTER OF CONCOR	CONCORD	, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D912	Continued From page	e 63	D912			
	(Type A2 Violation).]					
D914	G.S. 131D-21(4) Dec	laration of Residents' Rights	D914			
	Every resident shall h	ation of Residents' Rights ave the following rights: al and physical abuse, ion.				
	This Rule is not met a TYPE A2 VIOLATION	•				
	multiple residents from language, cussing, vio space in a hostile man a resident while yellin injections aggressivel needed (PRN) medica	plating a residents' personal nner, holding both wrists of g, administering insulin y, not administering as ation to residents, leaving causing residents to go to				
	The findings are:					
	-Staff B was a Medica floor and was "very m -Staff B "accused me not say." -Staff B "purposely di and Staff B "gave me PRN medication. -Most days MAs from	with a resident revealed: ation Aide (MA) on the 3rd lean to me." of saying things that I did d not give me medications" an attitude" if I ask for a other floors "gave me my B]did not have to deal with				
	revealed:	with a second resident ve me medications and one				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL013044	B. WING		1	0/4.4/2047
		•			14	2/14/2017
NAME OF P	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
THE LIVIN	NG CENTER OF CONCO	RD	RREN C. COLEMAN RD, NC 28027	N BLVD.		
	OLIMANA DV. OT			DDOV/IDEDIO DI ANI OF	COORDECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D914	Continued From page	e 64	D914			
	medications that I wo -After I made that sta give me my medication-Staff B "gives me and answers and abrupt a another floor having staff B "did not want Confidential interview revealed: -"I seen [Staff B] have roommate over her normate over her normate in the staff B] to say want [Staff B] to say	attement Staff B decided to cons. a attitude", being short with at times causing a MA from to given me my medications. to help or talk to me." with a third resident e an attitude with my nedications." to [Staff B] because I did not ugly things to me." oachable so I stay out of her				
	revealed: -"I do not like how [S -I heard Staff B "cuss upsets me." -"When I try to find so before I go to bed, I c floor for a long time."	omeone to help me at night cannot find anyone on the				
	B] was the only MA the injection that wayI heard [Staff B] in the loudly about other resultsStaff B was on the provery loudly, I did not	nsulin shot really hard", [Staff hat administered my insulin he hallway "cussing very				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND LEAN	O CONTROLON	IDENTIFICATION NOMIDEN.	A. BUILDING: _		JOSINII ELTED	
		HAL013044	B. WING		12/14/2017	
	20,4252.02.02.02.02				12/17/201/	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
THE LIVING CENTER OF CONCORD			REN C. COLEMA RD, NC 28027	AN BLVD.		
041114	CHMMADV CT		·	DDOVIDED'S DI ANI OF CODDECTION	1 000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D914	Continued From page	e 65	D914			
	-Staff B "is not very a	pproachable."				
	Confidential interview revealed: -"I had an incident with months ago[Staff B] "was given in the hallway before I was preparing myastaff B said "if I refusion was going to refusion." -"I felt she was purpoome to get me to say the want to say." -[Staff B] "was in my folia like killing you." -Staff B then backed of the ambulance"I was sent to the ER	with a sixth resident th [Staff B] about one or 2 me my medications out in vent to dinner." sing and yelling at me" while				
	had never said what I days in the hospitalSince that incident S	said and I would spent 3 taff B continued to "cuss at				
	me daily and get in my face." -[Staff B] provoked me to the point that "I just refuse to take my medications" and then in return [Staff B] "either gives me my insulin shot rough or					
	me my medications s deal with me."	er floors comes and gives o Staff B does not have to				

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said that he would handle things but nothing has

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COIVIE	LETED
		HAL013044	B. WING	B. WING		/14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE	-	
		160 WAR	REN C. COLEMA			
THE LIVIN	IG CENTER OF CONCOR	RD	D, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D914	Continued From page	÷ 66	D914			
D914	revealed: -The MA on the 3rd fl together with the PCA and no one is on the may need help during -There are times that 1st floor to ask anoth and give me my med medication because the be foundIt is dangerous for no for such a long period	ask for help or my taff B] is working." with a seventh resident oor on 2nd shift go on break A over 20 minutes at a times floor to help anyone that g that time. I have to go to 2nd floor or er MA to come to 3rd floor ications for a PRN the MA on 3rd floor cannot to staff to be on the 3rd floor d of time. and get hurt and no one	D914			
	revealed: -Initially, they were af Resident Care Coord family member and S was a MA in the facili -They were afraid of g -There was an incide months ago with a reIn April, 2017, staff n 3rd floor by a PCA, "I both hands on the res was "in the resident's the resident and cuss stopped the incident I between them. Staff I of the shift that nightStaff members repor to the former Adminis	getting fired. Int with Staff B about 6 Isident on the 3rd floor. Inembers were called to the Intwitnessed [Staff B] with Isident's wrists, and [Staff B] If ace". Staff B was yelling at Ising at him. Staff members Is between them by stepping Is continued to work the rest Ited the incident in April 2017				

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STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
		The Solid Medical Control of the Con				
		HAL013044	B. WING		12/1	4/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE LIVIN	IG CENTER OF CONCOR	RD	EN C. COLEMA	AN BLVD.		
(VA) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	, NC 28027	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D914	Continued From page	e 67	D914			
	2017 and then she re -Staff members continued in Staff BStaff B used inapprojob and disrespected and disrespected in the staff BResidents continue to other floors to ask for reasons that they can to help them or Staff B medicationsStaff did not feel comabout Staff B to admit due to multiple family worked at the facility.	priate language while on the authority. To come from 3rd floor to their medicines either for anot find anyone on 3rd floor B refused to give them their infortable reporting concerns nistration staff at this time members of Staff B who				
	Confidential telephone interview with a family member revealed: -"My family member called one night crying, she said the staff on 2nd shift were trying to get her to bed and called her a [expletive]. -The same night "my family member said the 2nd shift staff used the "N" word". -"My family member could not recall the name of the staff person who was disrespectful to her. -"I called two times to the facility to speak with the Administrator, but he did not return my call." -"Communication is a problem at the facility." "-I am currently looking for another place for my family member." -When we toured the facility it appeared to be a					
	great place, "but it cell Interview on 12/13/17 revealed: -Staff B was the Medi floor and worked 2nd -She dispensed medi the 3rd floor. -She was hired on 04	rtainly had changed". 7 with Staff B at 2:16 pm ication Aide (MA) for the 3rd shift. cations for the residents on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPI	LETED
		HAL013044	B. WING		12/	14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
NAME OF T	KOVIDEIK OK OOI I EIEK		REN C. COLEMA			
THE LIVIN	G CENTER OF CONCOR	RD	D, NC 28027	AN BLVD.		
	OUR MAR DV OT		'	DD0//DED0 D/ AV 05 00DD5		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP		DATE
				DEFICIENCY)		
D914	Continued From page	e 68	D914			
	on probation for 30 daher job.	ays and in jeopardy of losing				
	-She denied laying ha	ands on any resident				
		resident that she asked				
	other MAs to adminis					
	-In November 2017, t	he resident "got in my face				
	and ran over my foot	with his walker."				
		the Administrator office and				
	given a verbal warnin	g for the incident in				
	November 2017.					
	_	ive her instructions to report into the her instructions to report				
	was her family memb					
		like the way an insulin pen				
	"popped" when "I gav					
		the Supervisor, "I started				
	using a regular insulir	n syringe."				
		any other complaints by any				
	of the residents or sta					
		d so does everyone else" l				
		the time, that's just life". the Supervisor when she				
		a resident's room for an				
	extended period of tin					
	•	lents had gone to other				
		to administer medications				
	because she was off					
	-She was to report to	the Administrator with any				
	issues.					
	-She did not cuss in fi					
		eat all of the resident the				
		ecause of how they treat				
	me." -She was unaware wh	hat a Health Care Personnel				
		or if the facility had reported				
		ns to the HCPR in April 2017				
	or November 2017.	13 1.13. 13. 11. 11. 12. 17				
	Interview on 12/13/17	at 2:30 pm and at 3:06 pm				

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with the Administrator revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
			A. BOILDING.	A BOLESING.		
		HAL013044	B. WING		12	2/14/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
		160 WAR	REN C. COLEMAI	N BLVD.		
THE LIVIN	IG CENTER OF CONCOR	RD	D, NC 28027			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D914	Continued From page	e 69	D914			
D914	-He took over as Adm -He reviewed the inci in regard to Staff B an floorHe was aware of the with Staff B in regard behaviors to resident passHe was unaware mu complained about Sta regards to verbally at violating a residents' manner, holding both yelling, administering aggressively, not adm medication to resider unattended causing r to get there medicatio -He was aware Staff RCCIf Staff B had issues Staff B was to report -It was his expectatio was to be called for a needed by the MAs o -There was a Superv floors should never b The facility's the facili residents from Staff E language, cussing, vi	ninistrator 6 months ago. dent report from April 2017 and a resident on the third e incident in November 2017 to frustrations and s during the medication attiple residents had aff B to the survey team in cusive language, cussing, personal space in a hostile a wrists of a resident while insulin injections ministering as needed (PRN) ats, and leaving the floor residents to go to other floors ans. B's family member was the with residents on 2nd shift, to the Supervisor on 2nd shift assistance when she was or the PCAs. isor on 2nd shift and the	D914			
	a resident while yellir injections aggressive needed (PRN) medic the floor unattended other floors to get the resident who had per	ng, administering insulin ly, not administering as ation to residents, leaving causing residents to go to bir medications, and a asonal items (money and arm a lockable space. This				
	failure to assure residents were safe from					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL013044	B. WING		12/1	4/2017
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	·		
THE LIVIN	G CENTER OF CONCOR	RD	EN C. COLEMA), NC 28027	AN BLVD.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D914	interviews with resider Residents rights are the Additional training with Residents Rights and their rights are protect the Regional Ombuds convenience. -The Administrator with today 12/13/17. -The Administrator/deresident interviews to being violated, weekly months and then randeresident interviews to being violated, month randomly thereafter.	abuse placed them at ntinued abuse and eviolation. The following Plan of 7: sesignee will begin immediate ents and staff to determine in peing violated. Ith all staff regarding the importance of ensuring sted will be scheduled with sman at her earliest. Il contact the Ombudsman ensure their rights are not by for 4 weeks, monthly for 4 domly thereafter. To will conduct random ensure their rights are not ally times 4 and then	D914			
	2018.					

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