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Division of Health Service Regulation

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

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D 000	Initial Comments The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted an annual survey on December 11-13, 2017 with an exit conference via telephone on December 14, 2017.	D 000	See Attached Plan of corrections for all areas cited on this Report.	
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 2 of 6 sampled staff (Staff B and Staff D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR). The findings are: A. Review of Staff B's personal record revealed: -She was hired on 04/12/16 as a Medication Aide (MA). -She had no documentation of a Health Care Personnel Registry Check (HCPR) being completed prior to 12/13/17. Interview on 12/13/17 with Staff B at 2:16 pm revealed: -She was not aware of the facility doing a HCPR	D 137	[signature], LED 2/5/2018	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 2/5/2018

STATE FORM 6899 Y1H911 If continuation sheet 1 of 71

Acknowledged and reviewed 2/7/18 Jeanne S Robinson RN

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D 137	Continued From page 1 check on her prior to employment. -She was not aware what the HCPR was. B. Review of Staff D's personal record revealed: -She was hired on 11/30/17 as a Personal Care Aide (PCA). -There was no documentation of a Health Care Personnel Registry Check (HCPR) completed prior to 12/13/17. 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. Interview on 12/13/17 with the Administrator at 3:06 pm revealed: -The Business Office Manager (BOM) sets up all of the staff records and he reviews them for completeness. -He could not explain why the previous Administrator did not did not complete the HCPR check on Staff B. -He remembered having to check the HCPR in November 2017 because of an allegation involving Staff B and resident abuse and had seen in Staff B's record a previous allegation in April for the same thing before he began working at the facility. -He is not sure where it went after he checked it in April. -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. -A report was not filed with the HCPR for the incident in April or in November 2017. -He could not locate a HCPR for Staff D. -A HCPR was supposed to be done upon hire on	D 137		

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D 137	Continued From page 2 all new staff. -A copy of the HCPR was requested from the Administrator for Staff B and D but not provided. The facility failed to assure 2 of 6 sampled staff (Staff B and Staff D) had a North Carolina Health Care Personnel Registry check prior to date of hire. The failure of the facility to know if staff had substantiated findings and after Staff B had 2 previous allegations of abuse was detrimental to the safety of the residents for neglect and abuse and constitutes a Type B Violation. The facility provided a Plan of Protection as follows: -Additional training with managerial staff that are responsible for the HR files regarding other staff qualifications. -Administrator/BOM shall conduct audits of employee files to ensure compliance per regulations and facility policy. -The use of an employee checklist will be implemented and used in each current employee file and employee files upon hire going forward to ensure compliance. Administrator/designee will perform random employee files audits monthly x 6 months, then randomly thereafter to ensure continued compliance per regulation and facility policy. -The Regional Director will conduct monthly random employee file audits to ensure policies are being followed. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 1, 2018.	D 137		

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D 257	Continued From page 3	D 257		
D 257	10A NCAC 13F .0801(d) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (d) If a resident experiences a significant change as defined in Paragraph (c) of this Rule, the facility shall refer the resident to the resident's physician or other appropriate licensed health professional such as a mental health professional, nurse practitioner, physician assistant or registered nurse in a timely manner consistent with the resident's condition but no longer than 10 days from the significant change, and document the referral in the resident's record. Referral shall be made immediately when significant changes are identified that pose an immediate risk to the health and safety of the resident, other residents or staff of the facility. This Rule is not met as evidenced by: Based on interview, and record review, the facility failed to refer 1 of 1 sampled resident with a 30 day weight loss greater than 5% of body weight to the physician or another appropriate licensed health professional within 10 days of identifying the weight loss (Resident #4). Review of Resident #4's current FL2 dated 7/27/17 revealed diagnoses of hypertension, chronic obstructive pulmonary disease, osteoarthritis, hyperlipidemia, history of diverticulitis, and history of alcohol abuse. Review of Resident #4's Monthly Vital Signs Record for 2017 revealed: -Resident's recorded weight for October 2017 was 153 pounds. -Resident's recorded weight for November 2017 was 143.6 pounds. -Resident's recorded weight for December 2017	D 257		

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D 257	Continued From page 4 was 134 pounds. Resident #4' had a significant weight loss of 7% from October to November 2017 and 7% weight loss from November to December 2017. Review of Resident #4's record revealed there was no documentation Resident #4's physician had been contacted regarding significant weight loss. Interview with the Regional Resident Care Coordinator (RRCC) on 12/12/17 at 12:13 pm revealed: -She defined significant weight loss as 5% weight loss within 1 month and 10% weight loss within 6 months. -It was the facility Resident Care Coordinator's (RCC) responsibility to review monthly weights. -She was made aware today 12/12/17 that Resident #4 had significant weight loss after Resident #4's monthly weights were requested by a surveyor. -Resident #4's physician was in the building today and was made aware of her weight loss. -She was not aware if there had been any prior communication with Resident #4's physician regarding weight loss prior to today. -Documentation of any contact with Resident #4's physician should have been kept in Resident #4's record. -There was also a separate notebook where notes were kept, but she could not locate the notebook. -It was policy for the physician to be made aware of any significant weight loss. -Resident #4's Physician Assistant (PA) was in the facility today, 12/12/17, and was made aware of Resident #4's weight loss.	D 257		

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D 257	Continued From page 5 Interview with Resident #4's PA on 12/12/17 at 3:52 pm revealed: -She was not aware of Resident #4's weight loss since October 2017 until today when notified by the facility. -She would expect to have been made aware of ongoing weight loss issues. 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 today. -He expected Resident #4's physician to have been notified in November 2017 regarding her weight loss. -The RCC was responsible for contacting Resident #4's physician to report weight loss. Interview with the RCC on 12/12/17 at 4:15 pm revealed: -She had been working in her position since September 2017. -She was not aware Resident #4 had significant weight loss since October 2017. -It was her responsibility to review the monthly weights. -"I try to review them every month." -The medication aides (MA) were responsible for documenting monthly weights and contacting the physician if there was significant weight loss. -She did not know if Resident #4's physician had been made aware of weight loss. Interview with a MA on 12/12/17 at 4:48 pm revealed: -It was the MA's responsibility to check monthly weights and document them on the vital signs record. -The RCC was responsible for reviewing the monthly weights and reporting significant weight	D 257		

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D 257	Continued From page 6 loss to the physician. -She was not aware Resident #4 had weight loss. -She had not documented or reported any weight loss to Resident #4's physician.	D 257		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up with the physician for 5 of 10 sampled residents (Resident #2, #9, and #8) regarding physician orders for self-administration of medications; (Resident #4) regarding use of Ventolin inhaler; (Resident #11) regarding a mechanical soft therapeutic diet order. The findings are: A. Review of Resident #2's current FL-2 dated 3/7/17 revealed diagnoses included memory loss, hypertension, stroke, dyslipidemia. Review of Resident #2's record revealed: -There was no order or evaluation completed for the Resident #2 to self-administer his medications. -There was a standing order dated 6/20/17 for Imodium AD 2 mg (medication used to control symptoms of diarrhea) (1) capsule with each loose stool up to 8 doses in 24 hours, notify	D 273		

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D 273	Continued From page 7 physician for persistent diarrhea (24 hours). Interview with Resident #2 on 12/12/17 at 10:40 am revealed: -He had some over-the-counter (OTC) medications in his room that he administered to himself, purchased by his brother and sister-in-law. -He could not remember how long he had these medications in his room. -His doctor did not prescribe the OTC medications and he did not make her aware that he was taking them. -He had Imodium in room that he administered to help with diarrhea since he had recovered from colon cancer. -He had a cream that he rubbed on his body to help relieve pain when needed. -He had an OTC pain medication he administered whenever he had a headache. -He had OTC medications in his room because staff took too long to administer medications. -The medications had been removed by staff during the evening on 12/11/17. Telephone interview with Resident #2's Responsible Party (RP) on 12/12/17 at 9:25 am revealed: -Some OTC medications were purchased for Resident #2 because staff were slow to administer medications at times. -She could not remember when and exactly what she purchased, however remembered purchasing Imodium for Resident #2 to keep in his room for diarrhea. -She could not remember if the facility had a policy on self-administration. -Resident #2's physician had not been prescribed any of the OTC medications she purchased. -She had not notified staffshe purchased OTC	D 273		

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D 273	Continued From page 8 medications for 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. Review of Resident #2's record revealed no documentation his physician had been notified the resident had OTC medication in his room which he was self-administering and no physician order's for self-administering medications. Observations on 12/13/17 at 11:00 am of a box of medications removed from resident's rooms by the facility revealed: -The medications which belonged to Resident #2 were in a box with Resident #2's name and room number written with a permanent marker. - A 4 ounce (oz.) tube of ultra-strength muscle rub (medication used to muscle aches and arthritis pain). -15 soft gel tablets of 125 mg simethicone (medication used to treat gas pain, pressure, and bloating). -A 3 oz. tube of maximum strength thera-gesic cream (medication used to relieve pain). -100 tablets of ibuprofen (medication used to relieve pain, reduce fever). -48 tablets of Imodium AD (medication used to control symptoms of diarrhea) -1.76 oz. container of Vapor Rub (medication used as a cough suppressant and topical analgesic). Interview with the Nurse Practitioner for Resident #2 on 12/12/17 at 4:00 pm revealed: -She was not aware Resident #2 was self-administering OTC medications.	D 273		

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-If Resident #2 continued to take Imodium medication, he would be at risk for an electrolyte imbalance.
-All other OTC medications Resident #2 self-administered would cause no harm to his health.
-She expected the facility to notify her so she could assess the resident for self-administration of medication.
-She had not been notified by anyone at the facility that Resident #2 was self-administering OTC medications.

Interview with the Medication Aide (MA) on 12/12/17 at 3:45 pm revealed:
-She administered medications during 1st shift for Resident #2.
-She had never seen any OTC medications in Resident #2's room.
-She was not aware that Resident #2 was administering his own medications.
-She administered Resident #2's medications as listed on the MAR.
-She had never checked Resident #2 room for OTC medications.

Interview with the Personal Care Assistant (PCA) on 12/13/17 at 10:58 am revealed:
-She removed OTC medications from Resident #2's room on 12/11/2017 because residents did not have an order to self-administer medications.
-After removing medications, she left them in the office for the Administrator to review.
-She had not notified Resident #2's physician because she was not instructed to contact anyone after removing the medications.

Interview with the Resident Care Coordinator (RCC) on 12/12/17 at 5:30 pm revealed:
-MA's were responsible for administering

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Resident #2 medications.
-She was not aware Resident #2 was self-administering medications.
- She was not aware of medications being confiscated from Resident #2 room therefore she had not notified the physician or families.
-She would call the family or physician if there were any changes with medications.

Interview with the Administrator on 12/13/17 at 11:35 am revealed:
-He was not aware that Resident #2 had OTC medications in their room, until a PCA removed medications from room.
-The RCC was responsible for notifying the doctor of self-administration of medications.
-He was unsure if the doctor or family had been notified that the Resident #2 was administering medications and were removed from his room.
-Residents and families were notified during admission that the resident must give medications to MA or RCC to be administered and cannot be administered without an order.

2. Review of Resident #9's current FL-2 dated 6/12/17 revealed diagnoses included type 2 diabetes, hypertension, hyperlipidemia, anemia, chronic kidney disease, and history of transient ischemic attack.

Review of Resident #9' s record revealed:
-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 than 24 hours.

Interview with Resident #9 on 12/12/17 at 6:00

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pm revealed:
-He had OTC medications in his room which he administered to himself.
-He had several medications which included a cough medicine and Tylenol he used when he needed.
-He could not remember exactly how many medications he had in his room.
-The medications were removed at 2:00 am on 12/11/17 by 3 staff members.
-He 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 medications were purchased by his daughter.
-He thought he was capable of administering his own medications, as he administered when he lived at home.

Telephone interview with Resident #9's Responsible Party (RP) on 12/13/17 at 11:36 am revealed:
-OTC medications were purchased for Resident #9 because she felt Resident #9 was capable of administering his own medications.
-She purchased OTC medications for Resident #9 and did not notify staff the medications were in the room.
-She could not remember when and exactly what she purchased.
-She could not remember if the facility had a policy on self-administration.
-Resident #9's physician had not prescribed any of the OTC medications she purchased.
-She had not notified the physician the resident was self-administering OTC medications.

Review of Resident #9's medication administration record (MAR) for October,

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November, and December 2017 revealed there were no entries for any of the OTC medications Resident #9 reported.

Review of Resident #9's record revealed no documentation his physician had been notified the resident had OTC medication in his room that he was self-administering and no physician order's for self-administering medications.

Observations on 12/13/17 at 11:00 am of a box of medications removed from 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 acetaminophen (medication used to relieve pain).
-A 1.5 oz. of premium saline nasal spray (medication used to soothe dry nasal passages).
-14 tablets of 1200 mg guifenesin and 60 mg dextromethorphan (Also called Mucinex used to control cough)
-3 Salonpas Gel Patches containing 0.025% capsaicin and 1.25% menthol (medication used to relieve pain).
-0.33 oz. bottle of homeopathic ear ache drops (medication used to relieve ear discomfort).
-A 4.7 oz. tube of Aspercreme containing 10% irolamine salicylate (medication used to treat pain).
-1 Icy-Hot patch medicated with menthol 5% (medication used to relieve pain).
-100 ibuprofen tablets (medication used to relieve pain, reduce fever).
-1.76 oz. container of Vapor Rub (medication used as a cough suppressant and topical analgesic).

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-20 tablets of 125 mg simethicone (medication used to treat gas pain, pressure, and bloating).

Interview with a nurse from Resident #9's primary care physician's office revealed:
-The primary care physician (PCP) was not aware that resident was self-administering OTC medications.
-The PCP felt Resident #9 was capable of administering his own medications.
-The PCP expected to be notified with any changes in medications or requests regarding medications.

Interview with the Medication Aide (MA) on 12/12/17 at 3:45 pm revealed:
-She administered medications during 1st shift for Resident #9.
-She had never seen any OTC medications in Resident #9's room.
-She was not aware that Resident #9 was administering his own medications.
-She administered Resident #9's medications as listed on the MAR.
-She had never checked Resident #9 room for OTC medications.

Interview with the Personal Care Assistant (PCA) on 12/13/17 at 10:58 am revealed:
-She removed OTC medications from Resident #9's room on 12/11/2017 because residents did not have an order to self-administer medications.
-After removing medications, she left them in the office for the Administrator to review.
-She had not notified Resident #2 or Resident #9's physician because she was not instructed to contact anyone after removing the medications.

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

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D 273	Continued From page 14 -MA's were responsible for administering Resident #9 medications. -She was not aware Resident #9 was self-administering medications. -She was not aware of medications being confiscated from Resident #9 room therefore she had not notified the physician or families. -She would call the family or physician if there were any changes with medications. Interview with the Administrator on 12/13/17 at 11:35 am revealed: -He was not aware that Resident #9 had OTC medications in their room, until a PCA removed medications from room. -The RCC was responsible for notifying the doctor of self-administration of medications. -He was unsure if the doctor or family had been notified that the Resident #9 was administering medications and were removed from his room. -Residents and families were notified during admission that the resident must give medications to MA or RCC to be administered and cannot be administered without an order. C. Review of Resident #8's current FL2 6/26/17 revealed: -Diagnoses included dementia, depression, atrial fibrillation, anxiety, and coronary artery disease. -There were no medication orders for lubricant eye drops, triple antibiotic ointment, antiseptic wipes, or mentholatum ointment. Review of Resident #8's record on 12/13/17 revealed: -There was a physician's order for artificial tears solution 1.4 %, instill one drop in both eyes four times daily as needed for dry eyes (wait 3-5	D 273		

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minutes between different eye drops).
-There was no order to self-administer any medication.
-There was no documentation of a cognitive assessment for self-administration of medication.

Review of Resident #8's 6 month physician orders dated 6/26/17 revealed:
-There was an order for artificial tears and an order for patient to self-administer the artificial tears.
-There was no order for triple antibiotic ointment, antiseptic wipes, or mentholatum ointment.
-There was no order for self-administration of any other medications.

Review of Resident #8's Medication Administration Record (MAR) for October, November, and December 2017 revealed:
-An entry for artificial tears solution 1.4%, instill 1 drop in both eyes four times daily as needed.
-There were no entries for triple antibiotic ointment, antiseptic wipes, or mentholatum ointment.

Interview with Resident #8 on 12/13/17 at 9:05 am revealed:
-"Somebody came in my room and stole my eye drops."
-"I looked for my eye drops and couldn't find them. I don't know who took them."
-Her family member bought the eye drops for her.
-The eye drops were for dry eyes.
-She did not know if other residents came in her room.
-"I would have put some drops in their eyes if they had only asked."
-Resident #8 did not mention any other medications that were taken from her room.

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Interview with the Administrator on 12/13/17 at 9:29 am revealed:
-He had a Medication Aide (MA) to collect over-the-counter (OTC) medications from each resident's room after a cream was identified in a resident's room.
-"This was not the first time we have removed medication from resident's rooms. We do this about once a month."
-He was not aware Resident #8 had any OTC medication in her room.
-He was not aware Resident #8 had been complaining about having her eye drops taken out of her room.
-He assumed that Resident #8's family members brought the medication into the facility for her.
-He did not know if Resident #8 had an order to self-administer medication.
-He did not know if Resident #8 had a cognitive assessment completed to show that she was capable of self-administering her medication.
-Residents and families were notified upon admission that any OTC medication must be given to the MA.
-The Resident Care Coordinator (RCC) was responsible for ensuring that a physician's order to self-administer medication was in place for residents who kept OTC medications in their rooms.
-The RCC was in the process of contacting residents' physicians to notify them of residents who had been taking OTC medications that were found in their rooms.

Observations on 12/13/17 at 9:45 am of a box of medications removed from residents' rooms by the facility revealed:
-There were two 0.5 fluid ounce bottles of restore tears lubricant eye drops (used to treat dry eyes) in the original packaging with Resident #8's name

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D 273	Continued From page 17 and room number written on it. -There was a 1 ounce tube of triple antibiotic ointment (used to prevent infections) with Resident #8's name and room number written on it. -There was 1 count pack of first aide wipes (used to prevent infections) with Resident #8's name and room number written on it. -There two 1 ounce containers of mentholatum ointment (used to relieve minor muscle and joint pain) with Resident #8's name and room number written on them. A second interview with Resident #8 on 12/13/17 at 10:16 revealed: -"I'm supposed to take the eye drops 3 times a day." -The eye drops were covered up in the top drawer of her bedside table. -"I didn't give the eye drops to anyone. They took them." -"I did have a good bit of medicine, but they came and got it all out." -She called her family member and told her someone took her eye drops. -Resident #8's family member told her to tell the staff. -She did not know if her physician had written an order for her to self-administer her medication. Interview with a MA on 12/13/17 at 10:23 am revealed -She was not aware if Resident #8 had any OTC medication in her room. -She was not aware if Resident #8 was self-administering any medication or had a physician's order to self-administer medication. -Resident #8 had to have a physician's order for medication to be kept in her room. -It was the RCC's responsibility to ensure that a	D 273		

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physician's order to self-administer medication was in place for any OTC medications kept in a resident's room.

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 drops."
-She had purchased the eye drops and other medications for Resident #8 to keep in her room.
-Resident #8 had a "note" from her doctor stating that she could keep her eye drops in her room.
-She did not inform the staff she had brought in the other OTC medication for Resident #8.
-She was not aware Resident #8 needed a physician's order for OTC medication
-Facility staff had removed Resident #8's OTC medication from her room in the past.

Interview with a second MA on 12/13/17 at 2:30 pm revealed:
-She was not aware Resident #8 had OTC medications in her room.
-She did not know if Resident #8 had a physician's order to self-administer medication.
-It wal policy if OTC medication was found in a resident's room, the MA or RCC would take the medication out of the resident's room and contact the physician.

Interview with the RCC on 12/13/17 at 2:36 pm revealed:
-She was not aware Resident #8 had OTC medications in her room.
-She was not aware if Resident #8 had a physician's order to self-administer medication or if a cognitive assessment had been completed for Resident #8 to be able to safely self-administer medication.
-She was responsible for ensuring physician

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orders for self-administration of medication were obtained and for ensuring a cognitive assessment was completed every 6 months for residents who self-administered medications.
-She had not contacted Resident #8's physician to obtain an order to self-administer medication or had a cognitive assessment completed.

Telephone interview with a nurse from Resident #8's physician's office on 12/14/17 at 2:52 pm revealed:
-The physician was not aware Resident #8 was self-administering medications.
-The physician had not written an order for Resident #8 to self-administer medications.
-The physician did not know Resident #8 needed an order to self-administer medications she kept in her room.
-The facility did not ask for an order for Resident #8 to self-administer medications she kept in her room.
-If the facility would have asked for an order to self-administer the medications Resident #8 kept in her room, the physician would have written the order.

D. Review of Resident #4's current FL2 dated 7/27/17 revealed:
-Diagnoses included hypertension and chronic obstructive pulmonary disease (COPD).
-The medication orders included Ventolin inhaler, inhale 2 puffs via inhalation 4 times daily as needed for shortness of breath.

Review of Resident #4's record revealed a physician's order dated 8/31/17 to notify the physician if Resident #4 needed to use the rescue inhaler (Ventolin HFA AER) more than 3 times weekly.

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D 273	Continued From page 20 Review of Resident #4's Medication Administration Record (MAR) for October 2017 revealed: -An entry for Ventolin inhaler 2 puffs via inhalation 4 times daily as needed. -Ventolin was documented as administered 7 times during the week of 10/1/17 through 10/7/17. -Ventolin was documented as administered 7 times during the week of 10/8/17 through 10/14/17. -Ventolin was documented as administered 7 times during the week of 10/15/17 through 10/21/17. -Ventolin was documented as administered 5 times during the week of 10/22/17 through 10/28/17. -Ventolin was documented as administered 4 times from 10/29/17 through 10/31/17. Review of Resident #4's MAR for November 2017 revealed: -An entry for Ventolin inhaler 2 puffs via inhalation 4 times daily as needed. -Ventolin was documented as administered 4 times from 11/1/17 through 11/4/17. -Ventolin was documented as administered 5 times during the week of 11/12/17 through 11/18/17. -Ventolin was documented as administered 4 times during the week of 11/19/17 through 11/25/17. Review of Resident #4's MAR for December 2017 revealed: -An entry for Ventolin inhaler 2 puffs via inhalation 4 times daily as needed. -There were no documented entries where administration of Ventolin exceeded 3 times a week from 12/1/17 through 12/11/17.	D 273		

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D 273	Continued From page 21 Further review of Resident #4's record revealed no documentation Resident #4's physician had been notified that Resident #4 needed to use Ventolin Inhaler more than 3 times weekly. Interview with Resident #4 on 12/11/17 at 10:26 am revealed: -She had a diagnosis of COPD. -She used an inhaler when she became short of breath, usually in the evening. -She only used one inhaler. Interview with a first shift Medication Aide (MA) on 12/12/17 at 9:40 am revealed: -Resident #4 had an emergency inhaler to use as needed for shortness of breath. -She had not administered the emergency inhaler to Resident #4 during her shift. -She was not aware the physician needed to be notified if the inhaler was used more than three times a week. -It was Resident Care Coordinator's (RCC) responsibility to contact the physician regarding medication. Interview with the Regional RCC on 12/12/17 at 12:13 pm revealed: -She had been working at the facility daily since 11/13/17. -She was not aware of Resident #4's order for the physician to be contacted if Resident #4 needed to use her Ventolin inhaler more than 3 times a week. -If a physician needed to be contacted, staff should have made a note in the resident's record to document the communication with the phyisican. -"There used to be a separate notebook where staff notes were kept, but we can't find it." -It was the RCC's responsibility to contact the	D 273		

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D 273	Continued From page 22 physician regarding any issues with medications. Interview with Resident #4's Physician Assistant (PA) on 12/12/17 at 3:52 pm revealed: -Resident #4 had been stable. -She had not received any phone calls from the facility regarding medications since October 2017. -She was not aware Ventolin inhaler was being administered more than 3 times a week to Resident #4. -She would have expected to been notified that Resident #4 was using Ventolin more than 3 times a week. -Resident #4 needed to be put on a maintenance inhaler due to her excess need for Ventolin. Interview with the Administrator on 12/12/17 at 4:07 pm revealed: -He was not aware there was an order for the physician to be contacted if Resident #4 needed the Ventolin inhaler more than 3 times a week. -He was not aware Resident #4 had used the Ventolin inhaler more than 3 times a week and did not know if the physician had been contacted. -The RCC was responsible for monitoring medication use and contacting the physician with any medication issues. Interview with the RCC on 12/12/17 at 4:15 pm revealed: -She had worked in her current position since September 2017. -She was not aware that Resident #4 had been administered Ventolin inhaler more than 3 times a week. -She was not aware of the order for the physician to be contacted if Resident #4 needed Ventolin inhaler more than 3 times a week. -MAs were responsible for contacting the	D 273		

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physician with medication issues.
-She was not aware if the physician had been contacted regarding Resident #4 needing Ventolin inhaler more than 3 times a week.
-Documentation 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 8/31/17 revealed:
-Diagnoses included cerebellar atrophy, seizure disorder, schizophrenia, anemia, mild mitral valve regurgitation, and unsteady gait.
-There 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 chicken.
-One serving of mashed potatoes with brown gravy.
-One serving of mixed vegetables.
-One wheat dinner roll/bread.
-One pat of margarine.

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-One serving of vanilla ice cream.
-A beverage of choice.

Review of the therapeutic diet spreadsheet for MS diets to be served for the lunch meal service on 12/12/17 revealed the following items were to be served:
-One serving of ground fried chicken.
-One serving of mashed potatoes with brown gravy.
-One serving of green beans.
-One wheat dinner roll/bread.
-One pat of margarine.
-One serving of vanilla ice cream.
-A beverage of choice.

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 tea.
-Resident #11 said to staff, "What's that? I want what she has."
-Resident #11 pointed to a regular plate with a grilled chicken breast.
-Staff 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 tea.
-Staff offered to cut up Resident #11's chicken twice and Resident #11 said "no" twice to staff cutting her meat up.
-Resident #11 ate about 50% of her meal and had no difficulty with swallowing or choking.

Interview with the Dietary Manager on 12/12/17 at 9:01 am revealed:
-He and the dietary staff were employed by a

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contracted company and was only responsible for preparing and serving food according to the menus.
-It was the responsibility of the dietary staff to place food on resident's meal trays according to the resident's diet orders.
-Diet orders were listed on a card behind the serving line which listed each resident's name and their therapeutic diet.
-Therapeutic diet food items were on the serving line.
-He was aware Resident #11 had a physician's order for a MS diet.
-Resident #11 refused to eat a MS diet.
-He instructed staff to serve Resident #11 a MS diet and if she refused then serve her a regular meal.
-He and dietary staff did not document when Resident #11 refused to eat a MS diet.
-It was the responsibility of the facility staff to document, notify the physician, and to ensure residents have appropriate diet orders.
-He had notified facility staff Resident #11 had been refusing her physician ordered MS diet.

Interview with Resident #11 on 12/12/17 at 2:47 pm revealed:
-She was not on a special diet.
-She had not had a swallowing test performed or told that she was on a MS diet.
-The lunch meal on 12/12/17 was the first time that she had been given chopped meat.
-"I thought it was a mistake."
-She did not have any difficulties with eating or swallowing her food.
-She was served the same food as everyone else.
-She would not eat her meats chopped.

Interview with a Personal Care Aide (PCA) on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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12/12/17 at 2:56 pm revealed:
-She had worked at the facility for 3 weeks.
-She usually served meals in the dining hall during her shift.
-Resident #11 was on a "chopped" diet.
-She served meal trays to Resident #11 that were prepared by the dietary staff.
-The 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 eat.
-She had told the Administrator, Medication Aides (MA) and the Resident Care Coordinator (RCC) that Resident #11 had been refusing her MS diet.
-She did not know if the physician had been contacted regarding Resident #11 refusing her MS diet.

Interview with Resident #11's Physician Assistant (PA) on 12/12/17 at 3:52 pm revealed:
-Resident #11 had an order for a MS diet.
-She was not very familiar with Resident #11.
-She had not been notified Resident #11 had been refusing to eat a MS diet and was eating a regular diet.
-The facility may have notified the physician, but she was not aware if they had.
-There was a concern with aspirating if the diet order was for MS.
-She expected to be notified if a resident refused a MS diet so that the diet order could be re-evaluated.

Interview with the Administrator on 12/12/17 at 4:07 pm revealed:
-He was not aware Resident #11 had been refusing to eat a MS diet as ordered by the physician.
-The RCC was responsible for contacting the Resident #11's physician to report she had been

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noncompliant with the MS diet order.
-He was not aware if the physician had been notified Resident #11 was refusing to eat a MS diet.
-Resident #11's physician should have been notified she was refusing to eat a MS diet and the resident was eating a regular diet.
-He was usually made aware of clinical issues during daily clinical stand up meetings, but Resident #11's diet was never brought to his attention.

Interview with the RCC on 12/12/17 at 4:15 pm revealed:
-She has worked in her position since September 2017.
-She was responsible for updating the therapeutic diet list and making sure that the dietary staff was aware of any changes in diet orders.
-Resident #11 was ordered a MS diet.
-She was not aware Resident #11 had been refusing to eat a MS diet and was being served a regular diet.
-She did not know if any other staff were aware Resident #11 was refusing to eat a MS diet.
-When a resident refused to eat a physician ordered diet, the process was to make the physician aware and ask for recommendations from the physician.
-It was her responsibility to notify the physician Resident #11 was not following the ordered diet.
-She did not contact the physician regarding Resident #11's diet order because she was not aware Resident #11 was not eating the ordered MS diet.

Review of the regular menu for the dinner meal service on 12/12/17 revealed the following items were to be served:
-One bowl of cabbage and sausage soup.

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-Two saltine crackers.
-One deli sandwich with whole slices of meat.
-One serving of spring mix with dressing.
-One serving of chilled peaches.
-A beverage of choice.

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 bowl of cabbage and sausage soup.
-Two saltine crackers.
-One turkey salad sandwich.
-One serving of shredded lettuce with dressing.
-One serving of chilled peaches.
-A 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 tea.
-A 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 2017.
-She served residents in the dining hall during her shift.
-The dietary staff told them what to serve to each

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D 273	Continued From page 29 resident. -Resident #11 was on a MS diet. -"We're supposed to put the meal in front of her and when she refuses, we give her a regular meal." -Resident #11 always refused the MS diet. -She told dietary staff that Resident #11 refused the MS diet when served to her. -"I didn't know I was supposed to tell the MT, RCC, or Administrator." -She did not know if Resident #11's physician had been contacted regarding her refusal to eat the physician ordered diet. Review of Resident #4's record revealed no documentation Resident #11's physician was contacted regarding her refusing to eat a MS diet as ordered. Review of the facility physician communication log on 12/13/17 revealed no documentation to the physician regarding Resident #11 refusing to eat a MS diet as ordered.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 5 sampled residents (#11) with a physician's order	D 310		

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for a Mechanical Soft (MS) diet were served as ordered.

The findings are:

Review of Resident #11's current FL2 dated 8/31/17 revealed:
-Diagnoses included cerebellar atrophy, seizure disorder, schizophrenia, anemia, mild mitral valve regurgitation, and unsteady gait.
-There was a physician's order for a regular MS diet.

Review of the therapeutic diet list provided by the dietary manager dated 8/29/17 revealed resident 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 chicken.
-One serving of mashed potatoes with brown gravy.
-One serving of mixed vegetables.
-One wheat dinner roll/bread.
-One pat of margarine.
-One serving ofvanilla ice cream.
-A beverage of choice.

Review of the therapeutic diet spreadsheet for MS diets to be served for the lunch meal service on 12/12/17 revealed the following items were to be served:
-One serving of ground fried chicken.
-One serving of mashed potatoes with brown gravy.

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-One serving of green beans.
-One wheat dinner roll/bread.
-One pat of margarine.
-One serving of vanilla ice cream.
-A beverage of choice.

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 tea.
-Resident #11 said to staff, "What's that? I want what she has."
-Resident #11 pointed to a regular plate with a grilled chicken breast.
-Staff 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 tea.
-Staff offered to cut up Resident #11's chicken twice and Resident #11 said "no" twice to staff cutting her meat up.
-Resident #11 ate about 50% of her meal and had no difficulty with swallowing or choking.

Interview with the dietary manager on 12/12/17 at 9:01 am revealed:
-He and the dietary staff was employed by a contracted company and was only responsible for preparing and serving food according to the menus.
-It was the responsibility of the dietary staff to place food on resident's meal trays according to the resident's diet orders.
-Diet orders were listed on a card behind the serving line which listed each resident's name and their therapeutic diet.
-Therapeutic diet food items were on the serving

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line.
-He was aware Resident #11 had a physician's order for a MS diet.
-Resident #11 refused to eat a MS diet.
-He instructed staff to serve Resident #11 a MS diet and if she refused to then serve her a regular meal.
-He and dietary staff did not document when Resident #11 refused to eat a MS diet.
-It 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.

Review of the regular menu for the dinner meal service on 12/12/17 revealed the following items were to be served:
-One serving of cabbage and sausage soup
-Two saltine crackers.
-One deli sandwich with whole slices of meat.
-One serving of spring mix with dressing.
-One serving of chilled peaches.
-A beverage of choice.

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 soup.
-Two saltine crackers.
-One turkey salad sandwich.
-One serving of shredded lettuce with dressing.
-One serving of chilled peaches.
-A 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

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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 tea.
-A 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 second PCA on 12/12/17 at 5:23 pm on revealed:
-She had been working at the facility since August 2017.
-She served residents in the dining hall during her shift.
-The dietary staff told them what to serve to each resident.
-Resident #11 was on a MS diet.
-"We're supposed to put the meal in front of her and when she refuses, we give her a regular meal."
-Resident #11 always refused her MS diet.
-She told dietary staff Resident #11 refused her MS diet when served to her.
-"I didn't know I was supposed to tell the MT, RCC, or Administrator."
-She did not know if Resident #11's physician had been contacted regarding her refusal to eat the physician ordered diet.

Interview with Resident #11 on 12/12/17 at 2:47 pm revealed:
-She was not on a special diet.
-She had not had a swallowing test performed or told that she was on a MS diet.
-The lunch meal on 12/12/17 was the first time that she had been given chopped meat.

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-"I thought it was a mistake."
-She did not have any difficulties with eating or swallowing her food.
-They gave her what they served everyone else.
-She would not eat her meats chopped.

Interview with a Personal Care Aide (PCA) on 12/12/17 at 2:56 pm revealed:
-She had worked at the facility for 3 weeks.
-She usually served meals in the dining hall during her shift.
-Resident #11 was on a "chopped" diet.
-She served meal trays to Resident #11 that are prepared by the dietary staff.
-The 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 eat.
-She had told the Administrator, Medication Aides (MA) and the Resident Care Coordinator (RCC) that Resident #11 had been refusing her MS diet.
-She did not know if the physician had been contacted regarding Resident #11 refusing her MS diet.

Interview with Resident #11's Physician Assistant (PA) on 12/12/17 at 3:52 pm revealed:
-Resident #11 had an order for a MS diet.
-She was not very familiar with Resident #11.
-She had not been notified Resident #11 had been refusing to eat a MS diet and was eating a regular diet.
-The facility may have notified the physician, but she was not aware if they had.
-There was a concern with aspirating if the diet order was for MS.
-She expected to be notified if a resident refused a MS diet so the diet order could be re-evaluated.

Interview with the the Administrator on 12/12/17

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at 4:07 pm revealed:
-He was not aware Resident #11 had been refusing to eat a MS diet as ordered by the physician.
-The Resident Care Coordinator (RCC) was responsible for contacting the Resident #11's physician to report the resident had been noncompliant with the MS diet order.
-He was not aware if the physician had been notified Resident #11 was refusing to eat a MS diet.
-Resident #11's physician should have been notified Resident #11 was refusing to eat a MS diet and the resident was eating a regular diet.
-He was usually made aware of clinical issues during daily clinical stand up meetings, but Resident #11's diet was never brought to his attention.

Interview with the RCC on 12/12/17 at 4:15 pm revealed:
-She had worked in her position since September 2017.
-She was responsible for updating the therapeutic diet list and making sure the dietary staff was aware of any changes in diet orders.
-Resident #11 was ordered a MS diet.
-She was not aware Resident #11 had been refusing to eat a MS diet and was being served a regular diet.
-She did not know if any other staff was aware Resident #11 was refusing to eat a MS diet.
-When a resident refused to eat a physician ordered diet, the process was to make the physician aware and ask for recommendations from the physician.
-It was her responsibility to notify the physician Resident #11 was not following the ordered diet.
-She did not contact the physician regarding Resident #11's diet order because she was not

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D 310	Continued From page 36 aware Resident #11 was not eating the ordered MS diet.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews, the facility failed to protect 7 of 13 sampled residents (Resident #1, #5, #7, #10, #11, #12, #13 and #14) from verbally abusive language, cussing, violating a residents' personal space in a hostile manner, holding both wrists of a resident while yelling, administering insulin injections aggressively, not administering as needed (PRN) medication to residents, leaving the floor unattended causing residents to go to other floors to get their medications, and Resident #1 who had personal items (money and credit card) stolen from a lockable space. The findings are: Refer to TAG 914, G. S. 131D-21-4 Declaration of Resident Rights (Type A2 Violation).	D 338		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of	D 375		

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Medications
(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:
(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and
(2) specific instructions for administration of prescription medications are printed on the medication label.

This Rule is not met as evidenced by:
Based on 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.

Review of the Resident #2's record revealed:
-There was no order or evaluation completed for the Resident #2 to self-administer his medications.
-There was a standing order dated 6/20/17 for Imodium AD 2 mg (1) capsule with each loose stool up to 8 doses in 24 hours, notify physician for persistent diarrhea (24 hours).

Interview with Resident #2 on 12/12/17 at 10:40

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am revealed:
-He had some over-the-counter (OTC) medications in his room that he administered to himself, purchased by his brother and sister-in-law.
-He could not remember how long he had these medications in his room.
-His doctor did not prescribe the OTC medications and he did not make her aware that he was taking them.
-He had Imodium in room that he administered to help with diarrhea since he had recovered from colon cancer.
-He had a cream that he rubbed on his body to help relieve pain when needed.
-He had an OTC pain medication he administered whenever he had a headache.
-He had OTC medications in his room because staff took too long to administer medications.
-The medications had been removed by staff during the evening on 12/11/17.

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 #2 in the box included resident's name and room number written with a permanent marker.
- A 4 ounce (oz.) tube of ultra-strength muscle rub (medication used to muscle aches and arthritis pain).
-15 soft gel tablets of 125 mg simethicone (medication used to treat gas pain, pressure, and bloating).
-A 3 oz. tube of maximum strength thera-gesic cream (medication used to relieve pain).
-100 ibuprofen tablets (medication used to relieve pain, reduce fever).
-48 tablets of Imodium AD (medication used to control symptoms of diarrhea)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-1.76 oz. container of Vapor Rub (medication used as a cough suppressant and topical analgesic).

Telephone interview with Resident #2's Responsible Party (RP) on 12/12/17 at 9:25 am revealed:
-Some OTC medications are purchased for Resident #2 because staff are slow to administer medications at times.
-She could not remember when and exactly what she purchased, however remembered purchasing Imodium for Resident #2 to keep in room due to complications with diarrhea.
-She could not remember if the facility had a policy on self-administration.
-Resident #2's physician had not prescribed any of the OTC medications she purchased.
-She had not notified staff that she purchased OTC medications for 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.

Interview with the Nurse Practitioner for Resident #2 on 12/12/17 at 4:00 pm revealed:
-She was not aware Resident #2 was self-administering OTC medications.
-She had never completed an evaluation for Resident #2 to self-administer medications.
-If Resident #2 continued to take Imodium medication, he would be at risk for an electrolyte imbalance.
-All other OTC medications that Resident #2 self-administered would cause no harm to his health.
-She expected the facility to notify her so that she

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could assess the resident for self-administration of medication.
-She had not been notified by anyone at the facility that Resident #2 was self-administering OTC medications.

Interview with pharmacy representative on 12/13/17 at 11:12 am revealed:
-Prescriptions orders were received electronically from the facility or the physician.
-Resident #2 never had an order Imodium, thera-gesic, ibuprofen, vapor rub, muscle rub, or simethicone to be filled.
-OTC medications are not typically filled by the pharmacy.

Interview with a Medication Aide (MA) on 12/12/17 at 3:45 pm revealed:
-She had never seen any OTC medications in Resident #2's room.
-She was not aware that Resident #2 was administering his own medications.
-She administers Resident #2's medications as listed on the MAR.
-She never checked Resident #2 room for OTC medications.

Interview with the Resident Care Coordinator (RCC) on 12/12/17 at 5:30 pm revealed:
-She reviewed all medication orders and FL-2s.
-She would perform an evaluation regarding self-administration of medications if ordered.
-She had not completed an evaluation of Resident #2 to self-administer medications.
-The facility policy was that the resident had to have a signed physicians order and be re-evaluated by physician every 6 months.
-MA's were responsible for administering Resident #2 medications.
-She was not aware Resident #2 was

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self-administering medications.
- She was not aware of medications being confiscated from Resident #2 room therefore she had not notified the physician or families.
-She was responsible for verification of orders for self-administration.

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 medications.
-He was not aware that Resident #2 had OTC medications in their room, until a PCA removed medications from room.
- The RCC was responsible for notifying the doctor of self-administration of medications.
-He was unsure if the doctor or family had been notified that the Resident #2 was administering medications and were removed from his room.
-Residents and families were notified during admission that the resident must give medications to MA or RCC to be administered and cannot be administered without an order.
-Residents must be evaluated by facility RCC and physician prior to administering medications.

B. Review of Resident #9's current FL-2 dated 6/12/17 revealed diagnoses included type 2 diabetes, hypertension, hyperlipidemia, anemia, chronic kidney disease, and history of transient ischemic attack.

Review of the Resident #9's record revealed:

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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 than 24 hours. Interview with Resident #9 on 12/12/17 at 6:00 pm revealed: -He had OTC medications in his room that he administered to himself. -He 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 room. -The medications were removed at 2:00 am on 12/11/17 by 3 staff members. -He 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 acetaminophen (medication used to relieve pain). -A 1.5 oz. of premium saline nasal spray	D 375		

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(medication used to soothe dry nasal passages).
-14 tablets of 1200 mg guifenesin and 60 mg dextromethorphan (Also called Mucinex used to control cough)
-3 Salonpas Gel Patches containing 0.025% capsaicin and 1.25% menthol (medication used to relieve pain).
-0.33 oz. bottle of homeopathic ear ache drops (medication used to relieve ear discomfort).
-A 4.7 oz. tube of Aspercreme containing 10% irolamine salicylate (medication used to treat pain).
-1 Icy-Hot patch medicated with menthol 5% (medication used to relieve pain).
-100 ibuprofen tablets (medication used to relieve pain, reduce fever).
-1.76 oz. container of vapor rub (medication used as a cough suppressant and topical analgesic).
-20 tablets of 125 mg simethicone (medication used to treat gas pain, pressure, and bloating).

Telephone interview with Resident #9's Responsible Party (RP) on 12/13/17 at 11:36 am revealed:
- OTC medications are purchased for Resident #9 because she felt Resident #9 was capable of administering his own medications.
-She purchased OTC medications for Resident #9 and did not notify staff that medications were in the room.
-She could not remember when and exactly what she purchased.
-She could not remember if the facility had a policy on self-administration.
-Resident #9's physician had not prescribed any of the OTC medications she purchased.

Review of Resident #9's MAR for October, November, and December 2017 revealed there were no entries for any of the OTC medications

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Resident #9 reported he was taking.

Interview with a representative from Resident #9's primary care physician's office revealed:
- The primary care physician (PCP) was not aware that resident was self-administering OTC medications.
-PCP felt that Resident #9 was capable of administering his medications.
- PCP did not recall completing a self-administration form for resident to administer medications.
-PCP had not been notified by the facility that resident had been administering medications.
-PCP expected to be notified with any changes in medications or requests regarding medications.

Attempted interview with Resident #9 pharmacy on 12/13/17 at 11:35 am was unsuccessful.

Interview with a Medication Aide (MA) on 12/12/17 at 3:45 pm revealed:
-She had never seen any OTC medications in Resident #9's room.
-She was not aware that Resident #9 was administering his own medications.
-She administers Resident #9's medications as listed on the MAR.
-She never checked Resident #9 room for OTC medications.

Interview with the Resident Care Coordinator (RCC) on 12/12/17 at 5:30 pm revealed:
-She reviewed all medication orders and FL-2s.
-She would perform an evaluation regarding self-administration of medications if ordered.
-She had not completed an evaluation of Resident #9 to self-administer medications.
-The facility policy was that the resident had to have a signed physicians order and be

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re-evaluated by physician every 6 months.
-MA's were responsible for administering Resident #9 medications.
-She was not aware Resident #9 was self-administering medications.
- She was not aware of medications being confiscated from Resident #9 room therefore she had not notified the physician or families.
-She was responsible for verification of orders for self-administration.

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 #9 did not have an order to self-administer medications.
-He was not aware that Resident #9 had OTC medications in their room, until a PCA removed medications from room.
- The RCC was responsible for notifying the doctor of self-administration of medications.
-He was unsure if the doctor or family had been notified that the Resident #9 was administering medications and were removed from his room.
-Residents and families were notified during admission that the resident must give medications to MA or RCC to be administered and cannot be administered without an order.
-Residents must be evaluated by facility RCC and physician prior to administering medications.

C. Review of Resident #8's FL2 revealed:
-Diagnoses included dementia, depression, atrial fibrillation, anxiety, and coronary artery disease.
-There were no medication orders for lubricant

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eye drops, triple antibiotic ointment, antiseptic wipes, or mentholatum ointment.

Review of Resident #8's record revealed:
-There was a physician's order for artificial tears solution 1.4 %, instill one drop in both eyes four times daily as needed for dry eyes (wait 3-5 minutes between different eye drops).
-There was no order to self-administration of medication.
-There was no documetation of a cognitive assessment for self-administration of medication.

Review of Resident #8's 6 month physician orders dated 6/26/17 revealed:
-There was an order for artificial tears and an order for the resident to self-administer the artificial tears.
-There was no order for triple antibiotic ointment, antiseptic wipes, or mentholatum ointment.
-There was no order for self-administration of any other medication.

Review of Resident #8's Medication Administration Record (MAR) for October, November, and December 2017 revealed:
-An entry for artificial tears solution 1.4%, instill 1 drop in both eyes four times daily as needed.
-There were no entries for triple antibiotic ointment, antiseptic wipes, or mentholatum ointment.

Interview with Resident #8 on 12/13/17 at 9:05 am revealed:
-"Somebody came in my room and stole my eye drops."
-"I looked for my eye drops and couldn't find them. I don't know who took them."
-Her daughter bought the eye drops for her.
-The eye drops were for dry eyes.

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-She did not know if another resident came in her room.
-"I would have put some drops in their eyes if they had only asked."

Interview with the the Administrator on 12/13/17 at 9:29 am revealed:
-He had a Medication Aide (MA) to collect the over-the-counter (OTC) medications from each resident's room after a cream was identified by facility staff in a resident room on 12/12/17.
-He was not aware Resident #8 had any OTC medication in her room.
-He was not aware Resident #8 had been complaining about having her eye drops taken out of her room.
-He assumed Resident #8's family members brought the medication into the facility for her.
-He did not know if Resident #8 had an order to self-administer medication.
-He did not know if Resident #8 had a cognitive assessment completed to show that she was capable of self-administering her medication.
-Residents and families were notified upon admission that any OTC medication must be given to the MA.
-The Resident Care Coordinator (RCC) was responsible for ensuring a physician's order to self-administer medication was in place for residents who kept OTC medication in their room.
-The RCC was in the process of contacting the residents' physicians to notify them of residents who had been taking OTC medications that facility staff found in their rooms.

Observations on 12/13/17 at 9:45 am of a box of medications confiscated from residents by the facility revealed:
-There were two 0.5 fluid ounce bottles of restore tears lubricant eye drops (used to treat dry eyes)

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in the original packaging with Resident #8's name and room number written on it.
-There was a 1 ounce tube of triple antibiotic ointment (used to prevent infections) with Resident #8's name and room number written on it.
-There was 1 count pack of first aide wipes (used to prevent infections) with Resident #8's name and room number written on it.
-There two 1 ounce containers of mentholatum ointment (used to relieve minor muscle and joint pain) with Resident #8's name and room number written on them.

Second interview with Resident #8 on 12/13/17 at 10:16 revealed:
-"I'm supposed to take the eye drops 3 times a day."
-The eye drops were covered up in the top drawer of her bedside table.
-"I didn't give the eye drops to anyone. They took them."
-Resident #8 did not know who took her eye drops.
-"I did have a good bit of medicine, but they came and got it all out."
-She called her family member and told her that someone took her eye drops.
-Resident #8's family member told her to tell the staff.
-She did not know if the physician had written an order for the resident to self-administer her medication.

Interview with a MA on 12/13/17 at 10:23 am revealed
-She was not aware if Resident #8 had any OTC medication in her room.
-She was not aware if Resident #8 was self-administering any medications or had a

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physician's order to self-administer medication.
-Resident #8 had to have a physician's order for medication to be kept in her room.
-It was the RCC's responsibility to ensure a physician's order to self-administer medication was in place for any OTC medications kept in a resident's room.

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 drops.
-She had purchased the eye drops and other medications for Resident #8 to keep in her room.
-Resident #8 had a "note" from her doctor stating she could keep her eye drops in her room.
-She did not inform the staff she had brought in the other OTC medications for Resident #8.
-She was not aware Resident #8 needed a physician's order for OTC medications.
-Facility staff had confiscated Resident #8's OTC medication in the past.

Attempted telephone interview with Resident #8's physician on 12/13/17 at 11:15 am was unsuccessful.

Interview with a second MA on 12/13/17 at 2:30 pm revealed:
-She was not aware Resident #8 had OTC medications in her room.
-She was not aware if Resident #8 had a physician's order to self-administer medication.
-If OTC medications were found in a resident's room, the MA or RCC would take the medications out of the resident's room and contact the physician.

Interview with the RCC on 12/13/17 at 2:36 pm revealed:

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D 375	Continued From page 50 -She was not aware Resident #8 had OTC medications in her room. -She was not aware if Resident #8 had a physician's order to self-administer medication or if a cognitive assessment had been completed for Resident #8 to be able to safely self-administer medication. -She was responsible for ensuring physician orders for self-administration of medication were obtained and for ensuring a cognitive assessment was completed every 6 months for residents who self-administered medication. -She had not contacted Resident #8's physician to obtain an order to self-administer medication or had a cognitive assessment completed for her. Telephone interview with a representative from Resident #8's physician's office on 12/14/17 at 2:52 pm revealed: -The physician was not aware Resident #8 was self-administering medication. -The physician had not written an order for Resident #8 to self-administer medication. -The physician was not aware Resident #8 needed an order to self-administer medication she kept in her room. -The facility did not ask for an order for Resident #8 to self-administer medication she kept in her room. -If the facility would have asked for an order to self-administer the medication that Resident #8 kept in her room, the physician would have written the order.	D 375		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry	D 438		

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D 438	Continued From page 51 The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed assure suspected allegations of verbal and mental abuse were reported to the Health Care Personnel Registry (HCPR) related to 1 sampled staff (Staff B) a Medication Aide (MA) who was mentally and abusively mistreating multiple residents. The findings are: Confidential interviews with six residents revealed: -One resident said Staff B was "very mean to me, accused me of saying things I did not say." -Three residents said Staff B did not administer medications to them. -One resident said Staff B "got an attitude" when I ask for an as needed (PRN) medication. -One residents said "Medication Aide (MA) from other floors had given medications, so Staff B "does not have to deal with me." -Staff B refused to give my medications so I told her "I was calling the police, after that she decided to give me my medications." -Other MAs administered medications because Staff B "does not want to help me or deal with me." -One resident said "I have seen Staff B have an attitude with my roommate over her medications".	D 438		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	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 REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 438	Continued From page 52 -One resident said "I stay out of her way because I do not want Staff B to be ugly to me". -"I heard Staff B in the hallway cussing so I do not ask for my medications." -Staff B was not approachable "so I stay out of her way and do not ask for help". -When Staff B worked "I could not find anyone on the floor when I needed my medications or help". -Staff B would leave to smoke for 20-30 minutes at a time leaving the residents unattended. -When Staff B administered insulin she "hurts my arm". -Staff B had gotten "in my face on one occasion and kept yelling at me, hit me and you will go to jail". -"I refused medications and insulin shots because [Staff B] always complained and tried to get me mad." -"I feel like Staff B tries to provoke me by cussing me, getting in my face, and refusing to give me my medications." -Other facility staff were aware Staff B was mean and verbally abuse to residents. -"I have gone to the Administrator and reported my concerns to him, but nothing has been done." -"I do not feel safe asking for medications when Staff B is working." Confidential interview with multiple staff revealed: -Initially, they were afraid to talk because the Resident Care Coordinator (RCC) was Staff B's family member and Staff B's other family member worked in the facility as well. -They were afraid of getting fired because the RCC was Staff B's family member. -Staff said, Staff B talked to residents "smart mouth, yelled and argued with residents, and said harsh words and even cussed." -They had not observed Staff B hit residents, but they were aware residents did not like the way	D 438		

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Staff B treated them.
-Staff B had been reported to the previous Administrator in April 2017 for "getting in a resident's face while holding the resident wrists down on the walker."
-In April 2017 Staff B had to be separated by staff from the resident and had threatened to call the law on the resident.
-Staff B was suspended for a few days and then returned to work.
-Staff B would cuss residents and would talk down to residents she did not like on the third floor.
-Residents would go to other floors to have their medications administered.
-One resident complained to a staff person a few months ago Staff B hurt his arm when she administered insulin.
-Staff were sure the Administrator was aware of Staff B's attitude toward residents because Staff B's behaviors had been going on since April 2017 when Staff B had been suspended.

Review on 12/13/17 of a Facility Action form for Staff B revealed:
-Documented April 2017 Staff B had been counseled by a former Administrator in regards to making disrespectful comments to residents, Staff B had received additional training on resident rights, random unannounced resident interviews were conducted by facility management in October and November 2017, Residents had not disclosed any negative comments about Staff B.
-Documentation in November 2017 another incident occurred, Staff B was counseled in regards to her frustrations with residents who were demanding medications during the medication pass, interventions for reducing and managing Staff B frustration included walking

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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 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 ran over my foot with his walker."

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-She was called into the Administrator's office was given verbal warning.
-The Administrator gave her instructions to report all issues with the resident to him because the RCC was a family member.
-One resident did not like the way an insulin pen "popped when I gave the insulin" theycomplained about it to the supervisor, "I started using a regular insulin syringe."
-She "would never lay a hand on a resident", she "would hug them".
-"I have bad days and so does everyone else, so I can't be 100 % all of the time. that's just life."
-She had not contacted the supervisor when she left the floor or had been in a resident's room for an extended period of time.
-Sometimes she would be in a resident's room for 45 minutes giving personal care, "maybe that's when residents cannot find me on the floor."
-The Personal Care Aide (PCA) would cover the floor when she went to smoke or left the floor for 15 or 20 minutes.
-She was aware residents had gone to other floors to get the MAs to give them their medications because she was off of the floor.
-She did not cuss in front of the residents.
-She did not know why residents or staff would say anything about her "attitude".
-"I am not going to treat all of the residents the same all of the time because of how they treat me."
-She was not aware of why she was called into the office on (12/13/17) until the Administrator called her in for accusations from the staff and residents about her behaviors and attitude, verbally abusive language, getting in resident's face, painful injections, medications being withheld, not being able to located when needed, and "laying hands on a resident".
-She was unaware what a Health Care Personnel

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Registry (HCPR) was or if the facility had reported the alleged accusations to the HCPR in April 2017 or November 2017.

Interview on 12/13/17 at 2:30 pm and at 3:06 pm with the Administrator revealed:
-He took over as Administrator 6 months ago.
-He was aware of the incident that occurred in April 2017 in regards to Staff B and a resident on the third floor.
-The report in April 2017 was initiated by the previous Administrator.
-Staff B had been suspended in April 2017, and then returned to work.
-Staff B was not reported to the HCPR at that time in April 2017.
-He completed an incident report in November 2017 in regards to Staff B behaviors and frustration with residents during the medication pass.
-He had given a verbal warning to Staff B in November 2017.
-He had not reported the allegation regarding Staff B in November 2017 to the HCPR.
-He was aware any allegations of abuse or neglect were to be reported to the HCPR within 24 hours and a 5 day investigation was to occur.
-He did not know multiple residents had complained about Staff B in regards to verbally abusive language, cussing, violating a residents' personal space in a hostile manner, holding both wrist of a resident while yelling, administering medication aggressively related to insulin injections, not administering as needed (PRN) medication to residents, and leaving the floor unattended causing residents to go to other floors to get there medications.
-He was aware Staff B's family member was the RCC.
-All the MAs reported to the RCC except Staff B,

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D 438	Continued From page 57 she reported to the Administrator. -He was unaware of some of the details Staff B had given during the interview until 12/13/17. -There was as supervisor on 2nd shift and the floors should never be left unattended. -It was Staff B's responsibility if she left the floor to contact the supervisor to cover the floor. -He had suspended Staff B on 12/13/17. -He would report the allegations to the HCPR on 12/13/17 and complete a 5 day investigation in regards to Staff B's behaviors. 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. The facility provided the following Plan of Protection on 12/13/17: -Immediately, the Administrator will report the allegations of resident abuse, neglect or exploration to the HCPR. -The Administrator will begin an internal investigation on all the allegations of abuse. -Immediately, the accused (Staff B) will be suspended pending the results of the investigation. -The Administrator will conduct random residents and staff interviews to ensure residents rights are not being violated, weekly for 4 weeks, monthly	D 438		

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D 438	Continued From page 58 for 4 months and then randomly thereafter. -The Regional Director and the Human Resource department will conduct random resident interviews and staff interviews to ensure resident rights are not being violated, monthly times 4 and then randomly thereafter. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, January 28, 2018.	D 438		
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. 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: Interview with Resident #2 on 12/12/17 at 10:40 am revealed: -He had some over-the-counter (OTC) medications in his room that he administered to himself, purchased by his brother and sister-in-law. -He had OTC medications in his room because staff took too long to administer medications.	D911		

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D911	Continued From page 59	D911		

-The medications had been removed by staff during the evening on 12/11/17.
-He remembered "three nurses coming in the room to take medications, they did not ask, they took them".
-He felt "upset" that the staff came "in the middle of the night" to take items that belonged to him".
-He did not understand why the medications had to be taken out of the room "late at night while sleeping".

Telephone interview with Resident #2 Responsible Party (RP) on 12/12/17 at 9:25 am revealed:
-She was not aware that the resident's medication were taken by staff.
-She was "not pleased with how medication were taken out of the room"
-She felt "someone could have called to notify that this was going to take place".

Interview with Resident #9 on 12/12/17 at 6:00 pm revealed:
-He had OTC medications in his room that he administered to himself.
-He 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 room.
-The medications were removed at 2:00 am on 12/11/17 by 3 staff members.
-He was "mad" that staff removed items and woke him up from sleeping to take medications his family member brought.
- He was "confused" and "hard of hearing" did not understand why staff were in his room so late at night.
-He felt "people should not have to live like that".

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Telephone interview with Resident #9 Responsible Party (RP) on 12/13/17 at 11:36 am revealed:
- OTC medications are purchased for Resident #9 because she felt that resident #9 was capable of administering his own medications.
-She was not notified that medications were going to be removed from residents' room.
-She called and spoke with someone at the facility who explained why medications were removed.
-She was "not pleased with how his sleep was interrupted to remove medications".

Observations on 12/13/17 at 11:00 am of a box of medications removed from residents room by the facility revealed:
-Medications from Resident #2 and #9.
-All medications that belonged to Resident #2 and Resident #9 in the box included resident's name and room number written with a permanent marker.

Interview with Personal Care Assistant (PCA) on 12/13/17 at 10:58 am revealed:
-She normally worked as a 2nd shift PCA.
-She worked until 2 am on 12/11/17.
-She 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 medications.
-She knew the few residents in the facility who had an order to self-administer medications.
-She removed OTC medications from Resident #2's and #9's room in the evening on 12/11/2017.
-She could not remember what time she went in the rooms to remove medications.
-She asked residents if she could remove the medications before taking them.
-The Administrator instructed her, if residents

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D911	Continued From page 61 refused to give medications to contact their family. -No resident refused to give medications found in their room. -After removing medications, she left them in the office for the Administrator to review. Interview with the Administrator on 12/13/17 at 11:35 am revealed: -Another resident in the facility had OTC medications in the room and he wanted to check with each resident to see if they had any OTC medication they may had been self-administering. -He instructed a 2nd shift PCA to go to all rooms in the building to ask for medications of residents who did not have an order to self-administer. -He was not aware that Resident #2 and #9 had OTC medications in their room, until a PCA removed medications from room. -He had not had a chance to notify families of the process to obtain OTC medications from residents. -He instructed the PCA to ask for medications, and if refused, he would speak with the resident on 12/12/17.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on record review and interviews, the	D912		

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D912	Continued From page 62	D912		

facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to other staff qualifications, health care personnel registry, and residents rights.

The findings are:

A. Based on observations, interviews, and record reviews, the facility failed to assure 2 of 6 sampled staff (Staff B and Staff D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR).[Refer to tag 137,10 A NCAC 13F.0407(a) (5) Other Staff Qualifications (Type B Violation).]

B.Based on record reviews and interviews, the facility failed assure allegations of verbal and mental abuse were reported to the Health Care Personnel Registry (HCPR) related to 1 sampled staff (Staff B) a Medication Aide (MA) who was mentally and abusively mistreating multiple residents.[Refer to tag 438, 10A NCAC 13F.1205 Health Care Personnel Registry (Type B Violation).]

C. Based on interviews, the facility failed to protect multiple residents from verbally abusive language, cussing, violating a residents' personal space in a hostile manner, holding both wrists of a resident while yelling, administering insulin injections aggressively, not administering as needed (PRN) medication to residents, leaving the floor unattended causing residents to go to other floors to get their medications, and a resident who had personal items (money and credit card) stolen from a lockable space.[Refer to tag 338,10A NCAC 13F.0909 Resident Rights

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D912	Continued From page 63 (Type A2 Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews, the facility failed to protect multiple residents from verbally abusive language, cussing, violating a residents' personal space in a hostile manner, holding both wrists of a resident while yelling, administering insulin injections aggressively, not administering as needed (PRN) medication to residents, leaving the floor unattended causing residents to go to other floors to get their medications. The findings are: Confidential interview with a resident revealed: -Staff B was a Medication Aide (MA) on the 3rd floor and was "very mean to me." -Staff B "accused me of saying things that I did not say." -Staff B "purposely did not give me medications" and Staff B "gave me an attitude" if I ask for a PRN medication. -Most days MAs from other floors "gave me my medications so [Staff B]did not have to deal with me." Confidential interview with a second resident revealed: -Staff B "refused to give me medications and one	D914		

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time I told [Staff B] if she did not give me my medications that I would call the police."
-After I made that statement Staff B decided to give me my medications.
-Staff B "gives me an attitude", being short with answers and abrupt at times causing a MA from another floor having to given me my medications.
-Staff B "did not want to help or talk to me."

Confidential interview with a third resident revealed:
-"I seen [Staff B] have an attitude with my roommate over her medications."
-"I did not say much to [Staff B] because I did not want [Staff B] to say ugly things to me."
-[Staff B] "is not approachable so I stay out of her way and do not ask for her help."

Confidential interview with a fourth resident revealed:
-"I do not like how [Staff B] talks to me."
-I heard Staff B "cussing in the hallway and that upsets me."
-"When I try to find someone to help me at night before I go to bed, I cannot find anyone on the floor for a long time."
-Sometimes I go to the second or first floor to get help.

Confidential interview with a fifth resident revealed:
-[Staff B] "gives my insulin shot really hard", [Staff B] was the only MA that administered my insulin injection that way.
-I heard [Staff B] in the hallway "cussing very loudly about other residents."
-Staff B was on the phone "yelling cuss words very loudly, I did not feel comfortable asking for my medication so I went back to my room without any medications."

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013044	A. BUILDING: _____ B. WING _____	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 REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D914	Continued From page 65 -Staff B "is not very approachable." Confidential interview with a sixth resident revealed: -"I had an incident with [Staff B] about one or 2 months ago. -[Staff B] "was given me my medications out in the hallway before I went to dinner." -[Staff B] "started cussing and yelling at me" while she was preparing my medications. -Staff B said "if I refused my medications then she was going to refuse to give me my insulin shot." -"I felt she was purposely yelling and cussing at me to get me to say things that I really did not want to say." -[Staff B] "was in my face" and I finally said "I feel like killing you." -Staff B then backed off and called the police and the ambulance. -"I was sent to the ER and was there for 3 days." -If Staff B would not provoked me then I would had never said what I said and I would spent 3 days in the hospital. -Since that incident Staff 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 refused to give it to me at all." -"Other MAs from other floors comes and gives me my medications so Staff B does not have to deal with me." -"I have stopped asking Staff B for any medications so that I can avoid an argument." -Several times I had gone to ask for help on 2nd shift and there is no one to be found for long periods of time. -I reported Staff B to the Administrator and he said that he would handle things but nothing has	D914		

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D914	Continued From page 66	D914		

changed.
-"I do not feel safe to ask for help or my medications when [Staff B] is working."

Confidential interview with a seventh resident revealed:
-The MA on the 3rd floor on 2nd shift go on break together with the PCA over 20 minutes at a times and no one is on the floor to help anyone that may need help during that time.
-There are times that I have to go to 2nd floor or 1st floor to ask another MA to come to 3rd floor and give me my medications for a PRN medication because the MA on 3rd floor cannot be found.
-It is dangerous for no staff to be on the 3rd floor for such a long period of time.
-Someone could fall and get hurt and no one would be there to help them.

Confidential interview with multiple facility Staff revealed:
-Initially, they were afraid to talk because the Resident Care Coordinator (RCC) was Staff B's family member and Staff B's other family member was a MA in the facility as well.
-They were afraid of getting fired.
-There was an incident with Staff B about 6 months ago with a resident on the 3rd floor.
-In April, 2017, staff members were called to the 3rd floor by a PCA, "I witnessed [Staff B] with both hands on the resident's wrists, and [Staff B] was "in the resident's face". Staff B was yelling at the resident and cussing at him. Staff members stopped the incident between them by stepping between them. Staff B continued to work the rest of the shift that night.
-Staff members reported the incident in April 2017 to the former Administrator the next day.
-Staff B was suspended for a few days in April

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D914	Continued From page 67	D914		

2017 and then she returned back at her job.
-Staff members continued to have issues with Staff B.
-Staff B used inappropriate language while on the job and disrespected authority.
-Residents continue to come from 3rd floor to other floors to ask for their medicines either for reasons that they cannot find anyone on 3rd floor to help them or Staff B refused to give them their medications.
-Staff did not feel comfortable reporting concerns about Staff B to administration staff at this time due to multiple family members of Staff B who worked at the facility. .

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 certainly had changed".

Interview on 12/13/17 with Staff B at 2:16 pm revealed:
-Staff B was the Medication Aide (MA) for the 3rd floor and worked 2nd shift.
-She dispensed medications for the residents on the 3rd floor.
-She was hired on 04/12/16.
-She was suspended for a week in April 2017, put

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D914	Continued From page 68	D914		

on probation for 30 days and in jeopardy of losing her job.
-She denied laying hands on any resident.
-There was only one resident that she asked other MAs to administer his medications.
-In November 2017, the resident "got in my face and ran over my foot with his walker."
-She was called into the Administrator office and given a verbal warning for the incident in November 2017.
-The Administrator gave her instructions to report all issues with residents to him because the RCC was her family member.
-One resident did not like the way an insulin pen "popped" when "I gave the insulin and complained about it to the Supervisor, "I started using a regular insulin syringe."
-She was unaware of any other complaints by any of the residents or staff.
-"I have bad days and so does everyone else" I can't be 100 % all of the time, that's just life".
-She had not contact the Supervisor when she left the floor or was in a resident's room for an extended period of time.
-She was aware residents had gone to other floors to get the MAs to administer medications because she was off of the floor.
-She was to report to the Administrator with any issues.
-She did not cuss in front of the residents.
-"I am not going to treat all of the resident the same all of the time because of how they treat me."
-She was unaware what a Health Care Personnel Registry (HCPR) was or if the facility had reported the alleged accusations to the HCPR in April 2017 or November 2017.

Interview on 12/13/17 at 2:30 pm and at 3:06 pm with the Administrator revealed:

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-He took over as Administrator 6 months ago.
-He reviewed the incident report from April 2017 in regard to Staff B and a resident on the third floor.
-He was aware of the incident in November 2017 with Staff B in regard to frustrations and behaviors to residents during the medication pass.
-He was unaware multiple residents had complained about Staff B to the survey team in regards to verbally abusive language, cussing, violating a residents' personal space in a hostile manner, holding both wrists of a resident while yelling, administering insulin injections aggressively, not administering as needed (PRN) medication to residents, and leaving the floor unattended causing residents to go to other floors to get there medications.
-He was aware Staff B's family member was the RCC.
-If Staff B had issues with residents on 2nd shift, Staff B was to report to the Supervisor.
-It was his expectation the Supervisor on 2nd shift was to be called for assistance when she was needed by the MAs or the PCAs.
-There was a Supervisor on 2nd shift and the floors should never be left unattended.

_____

The facility's the facility failed to protect multiple residents from Staff B who used verbally abusive language, cussing, violating a residents' personal space in a hostile manner, holding both wrists of a resident while yelling, administering insulin injections aggressively, not administering as needed (PRN) medication to residents, leaving the floor unattended causing residents to go to other floors to get their medications, and a resident who had personal items (money and credit card) stolen from a lockable space. This failure to assure residents were safe from

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D914	Continued From page 70 physical and mental abuse placed them at substantial risk for continued abuse and constitutes a Type A2 violation. The facility provided the following Plan of Protection on 12/13/17: -The Administrator/designee will begin immediate interviews with residents and staff to determine in Residents rights are being violated. -Additional training with all staff regarding Residents Rights and the importance of ensuring their rights are protected will be scheduled with the Regional Ombudsman at her earliest convenience. -The Administrator will contact the Ombudsman today 12/13/17. -The Administrator/designee will conduct random resident interviews to ensure their rights are not being violated, weekly for 4 weeks, monthly for 4 months and then randomly thereafter. -The Regional Director will conduct random resident interviews to ensure their rights are not being violated, monthly times 4 and then randomly thereafter. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 17, 2018.	D914		

February 5, 2018

Dear Ms. Robinson,

Please find attached with this email the signed SOD from the survey completed on December 14, 2017 at the Living Center of Concord and also the Plan of Correction. If you have any questions please contact me.

Respectfully,

Kenneth Hinkle
Administrator
The Living Center of Concord

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D 000	Initial Comments The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted an annual survey on December 11-13, 2017 with an exit conference via telephone on December 14, 2017.	D 000	See Attached Plan of Corrections for all areas cited on this Report.	
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 2 of 6 sampled staff (Staff B and Staff D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR). The findings are: A. Review of Staff B's personal record revealed: -She was hired on 04/12/16 as a Medication Aide (MA). -She had no documentation of a Health Care Personnel Registry Check (HCPR) being completed prior to 12/13/17. Interview on 12/13/17 with Staff B at 2:16 pm revealed: -She was not aware of the facility doing a HCPR	D 137		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 2/5/2018

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Non-Compliance Identified: 10A NCAC 13F. 0407(a)(5)-Other Staff Qualifications
(d) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the NC HCPR according to G.S. 131E-256

Facility Interventions:

1. Facility shall assure each staff person has no substantiated findings listed on the NC HCPR 12/15/2017 & on-going
2. Additional training with management staff responsible for HR files, hiring and new hire orientation regarding importance of pre-employment NC HCPR checks. 12/15/2017 & on-going

Monitoring System

1. Employee file checklists were implemented to ensure compliance with staff qualifications 12/13/2017 & on-going
2. Admin/designee will perform random employee file audits monthly x6 months, then randomly thereafter to ensure continued compliance per regulation and facility policy 12/13/2017 & on-going
3. Regional Director will perform random employee file audits monthly x6 months, then randomly thereafter to ensure continued compliance per regulation and facility policy 12/13/2017 & on-going

Non-Compliance Identified: 10A NCAC 13F. 0801(d)-Resident Assessment
(d) If a resident experiences a significant change the facility shall refer the resident to the resident's physician or other appropriate licensed health professional in a timely manner but no longer than 10 days from the significant change.

Facility Interventions:

1. Facility shall assure that if a resident experiences a significant change, referral will be made to resident's physician or other appropriate licensed health professional in a timely manner but no longer than 10 days from the significant change. 01/15/2017 & on-going
2. RCC/Designee will review weight documentation at least weekly and report any significant changes to the physician per the Md. order or within 10 days of the significant change 02/09/18 & ongoing
3. RCC has daily stand up meetings with the Medication Aides and SIC's to discuss and document resident related issues included but not limited to significant changes in the residents overall being. 2/9/2018 & ongoing.

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Monitoring System

1. Administrator/designee will conduct random chart audits, monitoring for significant changes in residents, weekly x4 weeks, then monthly x4 months and randomly thereafter. 02/10/2018 & on-going
2. RCC/Admin/Designee will conduct random resident interviews and assessments, to observe residents for significant changes; weekly x4 weeks, then monthly x4 months and randomly thereafter. 02/10/2018 & on-going
3. Corporate Quality Assurance shall randomly request proof of audits from the administrator, regional director and RCC to assure reviews are being completed. 02/10/2018 & ongoing

Non-Compliance Identified: 10A NCAC 13F. 0902(b)-Healthcare

(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

Facility Interventions:

1. The facility shall assure referral and follow-up meet the routine and acute health care needs of residents. 02/10/2018 & on-going
2. Administrator/designee will review resident records to assure referrals and follow ups are being scheduled and followed through with, in order to meet the routine and acute health care needs of residents. 02/10/2018 & on-going

Monitoring System:

4. RCC/designee will maintain Referral and Follow-up tracking form to ensure residents are seen by physician in a timely manner. 02/10/2018 & on-going
5. Administrator/designee will conduct random chart audits, monitoring for referral and follow-up, weekly x4 weeks, then monthly x4 months and randomly thereafter. 02/10/2018 & on-going
6. Administrator/designee will conduct random interviews with residents to ensure staff are addressing healthcare needs, weekly x4 weeks, then monthly x4 months and randomly thereafter. 02/10/2018 & on-going

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Non-Compliance Identified: 10A NCAC 13F. 0904(e)(4)-Nutrition and Food Service

(e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

Facility Interventions:

1. Facility shall assure all therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. 01/15/2018 & on-going
2. Staff will receive additional training on Dietary Policies and Procedures 02/10/2018
3. Implementation of Dietary Communication Form and training on use of form 02/10/2018

Monitoring System

1. Administrator/designee shall conduct random resident interviews and meal observations, weekly x4 weeks then monthly x4 months and randomly thereafter, to ensure residents are receiving meals according to physician's order 02/10/2018 & on-going
2. Administrator/designee shall conduct random staff interviews, weekly x4 weeks then monthly x4 months and randomly thereafter, to ensure that communication forms are being used and to ensure that staff are reporting residents being non-compliant with their diets to the RCC so that resident's physician can be contacted. 02/10/2018 & on-going

Non-Compliance Identified: 10A NCAC 13F .0909-Resident Rights

An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21 are maintained and may be exercised without hindrance.

Facility Interventions:

1. Facility staff will receive additional training on Resident's Rights to begin no later than 01/17/2018
2. Administrator/designee will begin immediate interviews with residents and staff to determine if Resident Right's are being violated. 12/14/2017 & on-going
3. RCC/Admin shall assure that residents having physician's order to keep medications at bedside and self-administer are permitted to do so and that company policy is being followed. 12/17/2017 & on-going

Monitoring System:

1. Administrator/designee will conduct random resident interviews to ensure their rights are not being violated, weekly x4 weeks, then monthly x4 months and randomly thereafter.

12/17/2017 & on-going

2. Regional Director shall conduct random resident interviews to ensure their rights are not being violated, weekly x4 weeks, then monthly x4 months and randomly thereafter.
12/17/2017 & on-going
3. Residents will be given the opportunity to discuss concerns regarding violation of their rights during monthly resident councils meetings. 01/17/2018 & on-going

Non-Compliance Identified: 10A NCAC 13F .1205-Health Care Personnel Registry

The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102

Facility Interventions:

1. Administrator shall immediately report allegations of resident abuse, neglect or exploitation to the HCPR according to regulations. 12/13/2017 & on-going
2. Administrator will begin immediately investigation into report allegations of abuse, neglect or exploitation and accused employee will be suspended pending the results of the investigation
12/13/2017 & on-going

Monitoring System:

1. Administrator/designee will conduct random resident interviews to ensure their rights are not being violated, weekly x4 weeks, then monthly x4 months and randomly thereafter.
12/17/2017 & on-going
2. Regional Director shall conduct random resident interviews to ensure their rights are not being violated, weekly x4 weeks, then monthly x4 months and randomly thereafter.
12/17/2017 & on-going

Non-Compliance Identified: G.S. 131D-31 Declaration of Residents' 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. (2) To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. (4) To be free of mental and physical abuse, neglect and exploitation.

Facility Interventions:

1. Facility staff will receive additional training on Resident's Rights to begin no later than 01/17/2018

2. Administrator/designee will begin immediate interviews with residents and staff to determine if Resident Right's are being violated. 12/14/2017 & on-going

Monitoring System:

1. Administrator/designee will conduct random resident interviews to ensure their rights are not being violated, weekly x4 weeks, then monthly x4 months and randomly thereafter. 12/17/2017 & on-going
2. Regional Director shall conduct random resident interviews to ensure their rights are not being violated, weekly x4 weeks, then monthly x4 months and randomly thereafter. 12/17/2017 & on-going
3. Residents will be given the opportunity to discuss concerns regarding violation of their rights during monthly resident councils meetings. 01/17/2018 & on-going

Non-Compliance Identified: 10 NCAC 13F .1005 (a) Self- Administration of Medications

(a) An Adult Care home shall permit residents who are competent and physically able to self- administer their medications if the following requirements are met:
(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.

Facility Interventions:

1. Residents who desire, who are competent and who are physically able to self administer shall have orders to do so. 2/9/2018 & ongoing

2. Implementation of revised self-administration of medication policy to include referral to the resident's physician for self-administration orders and resident monthly compliance checklist. 12/14/2017 & ongoing

3. Training with RCC's and staff on Self-Administration of Medications Police. 12/14/17 & ongoing

4. A letter shall be sent to families to remind them of the self- administration policy and will be part of the admission process. 2/9/2018 & ongoing
5. Residents shall be reminded of the self- administration policy at monthly resident council meetings. 2/5/2018 & ongoing.

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Monitoring System:

1. RCC/designee will conduct random resident audits to assure policy is being followed. 2/5/2018 & on-going
2. Regional Director shall conduct random policy audits and record review to ensure self- administration policy is being followed monthly x4 months and randomly thereafter. 2/5/2018 & ongoing

Administrator Signature

2/5/2018
Date