

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	Initial Comments The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted a follow-up survey and a complaint investigation, (initiated 12/28/20), with an onsite visit date on 01/20/21 and 01/22/21, a desk review on 01/21/21 and 01/25/21, and a telephone exit on 01/26/21.	D 000		
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure referral and follow up to health care providers for 2 of 7 sampled residents (#6 and #4) regarding reporting of daily weights with parameters, refusals of daily weights and a month long delay in initiating a physical therapy (PT), occupational therapy (OT) and skilled nursing (SN) referrals (Resident #6); and refusals of a medication used to treat high blood pressure and regarding when to administer a medication used to treat high blood pressure, treat nerve pain, and indigestion, for a resident who had dialysis three days a week (Resident #4).</p> <p>The findings are:</p> <p>1. Review of Resident #6's current FL2 dated 10/29/20 revealed: -Diagnoses included heart failure, muscle weakness, and dementia. -There was an order to check a daily weight and notify the physician of loss/gain greater than 3</p>	D 273		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 1</p> <p>pounds (lbs).</p> <p>a. Review of Resident #6's October 2020 electronic Treatment Administration Record (eTAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry to check weight daily, notify provider if 3 lbs. or greater in one day or 5 lbs. or greater in one week. -Weights documented for the week of 10/01/20 to 10/07/20 ranged from 180-265 lbs. -Weights documented for the week of 10/08/20 to 10/14/20 ranged from 180-260 lbs. -Weights documented for the week of 10/15/20 to 10/21/20 ranged from 220-235 lbs. -Weights documented for the week of 10/22/20 to 10/28/20 ranged from 225-252 lbs. -Weights documented for the week of 10/29/20 to 10/31/20 was 225 lbs. -There was no documentation of physician notification. <p>Review of Resident #6's November 2020 eTAR revealed:</p> <ul style="list-style-type: none"> -There was an entry to check weight daily, notify provider if 3 lbs. or greater in one day or 5 lbs. or greater in one week. -The weights were not documented 23 out of 30 days and there was no justification of why the weights were not obtained. -There were 7 out of the 30 days documented as refused. -There was no documentation of physician notification. <p>Review of Resident #6's December 2020 eTAR revealed:</p> <ul style="list-style-type: none"> -There was an entry to check weight daily, notify provider if 3 lbs. or greater in one day or 5 lbs. or greater in one week. -There were 30 out of the 31 days documented 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 2</p> <p>as refused.</p> <ul style="list-style-type: none"> -There was a weight documented as 200 lbs. on 12/26/20. -There was no documentation of physician notification. <p>Review of Resident #6's January 2021 eTAR revealed:</p> <ul style="list-style-type: none"> -There was an entry to check weight daily, notify provider if 3 lbs. or greater in one day or 5 lbs. or greater in one week 01/01/21 to 01/22/21. -There were 15 out of the 22 days documented as refused. -There were 7 out of 22 weights documented ranging from 222.4 to 226.6 lbs. -There was no documentation of physician notification. <p>Review of Resident #6's progress notes revealed there was no documentation of notification to the physician related to Resident #6's weight increases.</p> <p>Review of Resident #6's physician's progress notes revealed there was no documentation of Resident #6's weight increases.</p> <p>Telephone interview with Resident #6's family member on 01/21/21 at 11:15am revealed:</p> <ul style="list-style-type: none"> -He was aware of Resident #6 having an exacerbation of Congestive Heart Failure (CHF). -Resident #6 informed him during their weekly phone calls, the swelling in her legs were getting worse. -He was not aware of the daily weights or the increased weight gains. <p>Interview with Resident #6 on 01/22/20 at 11:13am revealed:</p> <ul style="list-style-type: none"> -The medication aide (MA) weighed her in her 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 3</p> <p>wheelchair.</p> <ul style="list-style-type: none"> -She was wearing elastics wraps on both legs covering the lower parts of her legs but not the feet. -Both of her feet were swollen. -She was not short of breath. -She was unsure of her current weight. <p>Telephone interview with Resident #6's physician on 01/22/20 at 12:17pm revealed:</p> <ul style="list-style-type: none"> -The daily weights were ordered on Resident #6 because Resident #6 had congestive heart failure (CHF) and she was to be notified if Resident #6 had a daily weight gain of 3 lbs. in a day or 5 lbs. in a week. -She had no record of the weight gains of 3 lbs./5 lbs. documented or recalled. -The notification of the weight gains of 3 lbs./5 lbs. was a front line of defense to act quickly and prevent worsening of Resident #6's CHF exacerbation and hospitalization. -A weight gain of 3 lbs. in one day or 5 lbs. in a week without her being notified could lead to a build up of fluid in Resident #6's body which could lead to a CHF exacerbation and difficulty breathing. -She expected the facility to follow the orders and notify her of the weight gain immediately. <p>Interview with the Administrator on 01/22/20 at 2:55pm revealed:</p> <ul style="list-style-type: none"> -The MAs were responsible for documentation of all weights in the electronic Medication Administration (eMAR) or eTAR as ordered by the physician. -The MAs were responsible for notifying the physician of the weights that were greater than 3 lbs. in one day and 5 lbs. in one week. -The MAs were responsible for monthly audits of the eMARs, eTARs and orders for compliance, 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 4</p> <p>accuracy, blanks and refusals.</p> <p>Telephone interview with a MA/floor supervisor on 01/25/20 at 10:18am revealed:</p> <ul style="list-style-type: none"> -She took over as 3rd floor MA/floor supervisor 01/01/21. -After review of Resident #6's eTAR the previous MA/floor supervisor for Resident #6 should have notified the physician after a 3 lb. gain in a day or a 5 lb. gain in a week, at least 4 times in October 2020. -She was responsible after 01/01/21 to notify the physician if the weight gain happened. -Resident #6 averaged a weight of 222.6 lbs. daily. -She weighed Resident #6 in the same wheelchair daily unless Resident #6 refused. -She would document the weights in Resident #6's eTAR and did not have to notify the physician for a weight gain during the month of January 2021. <p>b. Review of Resident #6's November 2020 eTAR revealed:</p> <ul style="list-style-type: none"> -There was an entry to check weight daily, notify provider if 3 lbs. or greater in one day or 5 lbs. or greater in one week. -There were 7 out of the 30 days documented as refused. -There was no documentation of physician notification. <p>Review of Resident #6's December 2020 eTAR revealed:</p> <ul style="list-style-type: none"> -There was an entry to check weight daily, notify provider if 3 lbs. or greater in one day or 5 lbs. or greater in one week. -There were 30 out of the 31 days documented as refused. -There was no documentation of physician 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 5</p> <p>notification.</p> <p>Review of Resident #6's January 2021 eTAR revealed:</p> <ul style="list-style-type: none"> -There was an entry to check weight daily, notify provider if 3 lbs. or greater in one day or 5 lbs. or greater in one week 01/01/21 to 01/22/21. -There were 15 out of the 22 days documented as refused. -There was no documentation of physician notification. <p>Review of the facility policy on refusals revealed following 3 refusals the physician will be contacted and the MA/floor supervisor made aware and documentation will be made in the residents chart.</p> <p>Review of Resident #6's progress notes revealed there was no documentation of notification to the physician related to Resident #6's weight refusals.</p> <p>Review of Resident #6's physician progress notes revealed there was no documentation of the physician being notified of Resident #6's weight refusals.</p> <p>Interview with the Administrator on 01/22/20 at 2:55pm revealed:</p> <ul style="list-style-type: none"> -The MAs were responsible for documentation of all weights in the electronic Medication Administration (eMAR) or eTAR as ordered by the physician. -The facility policy for refusals was to report the refusal to the MA/floor supervisor, document in the resident's record and notify the physician after 3 refusals in a row. -The MAs were responsible for monthly audits of the eMARs, eTARs and orders for compliance, 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 6</p> <p>accuracy, blanks and refusals.</p> <p>-The MAs were responsible for the notifications of the refusals to the physician.</p> <p>Telephone interview with Resident #6's physician on 01/22/20 at 12:17pm revealed:</p> <p>-The daily weights were ordered on Resident #6 because Resident #6 has congestive heart failure (CHF) and she was to be notified if Resident #6 refused weights after 3 days in a row.</p> <p>-The notification of the weight gains of 3 lbs./5 lbs. was a front defense to act quickly and she needed to know about the refusals after 3 days in order to determine the next action to take to prevent worsening of Resident #6's CHF exacerbation and hospitalization.</p> <p>-There was no documentation in her notes related to refusals.</p> <p>--She did not recall a notification from the facility staff relating to Resident #6's refusals.</p> <p>-She expected the facility to follow the orders and notify her of the refusals immediately after 3 days.</p> <p>Telephone interview with a MA/floor supervisor on 01/25/20 at 10:18am revealed:</p> <p>-After review of Resident #6's eTAR the previous MA/floor supervisor for Resident #6 should have notified the physician after 3 refusals in a row in November 2020 where there were 7 days in a row and 23 days of blank documentation and there were 30 days in December 2020 of refusals.</p> <p>-She was responsible after 01/01/21 to notify the physician if 3 refusal in a row happened.</p> <p>-Resident #6 refused many times in January 2021 and she notified the physician most of the time but did not document it on the eTAR, eMAR, or care notes in Resident #6's record because she forgot.</p> <p>-Resident #6 would refuse for reasons of being tired, doing something else or just did not want to</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 7</p> <p>go.</p> <ul style="list-style-type: none"> -She did not go back and try later to take her weight because the next shift would attempt the weight and she did not go back and check to see if the weight was obtained. -She thought the next shift MA could get Resident #6 weighed. -She did not check the eTAR to see if Resident #6 was weighed because she was responsible for all of the COVID-19 testing and results which kept her busy. -The MAs and the floor supervisors were responsible for eTAR audits. -She completed monthly eTAR audits when she was able to when she had time which was when she would have caught the refusals not being reported to the physician. <p>c. Review of Resident #6's physician visit orders dated 11/04/20 revealed a referral for Resident #6 to home health for PT/OT/skilled nursing (SN) due to Congestive Heart Failure (CHF) exacerbation/decline in Activities of Daily Living (ADLs) care and lower extremities edema.</p> <p>Review of Resident #6 signed physician order dated 12/22/20 revealed a second referral for Resident #6 to home health for PT/OT/skilled nursing (SN) due to Congestive Heart Failure (CHF) exacerbation/decline in Activities of Daily Living (ADLs) care and lower extremities edema.</p> <p>Observation of Resident #6 on 01/22/21 at 11:13am revealed:</p> <ul style="list-style-type: none"> -Resident #6 was sitting in her wheelchair. -She had tight elastics wraps on both lower legs from her knees down to mid foot. -Both of her feet from mid foot to the end of her toes were swollen up higher than the wraps. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 8</p> <p>Review of Resident #6's SN note dated 01/15/21 revealed:</p> <ul style="list-style-type: none"> -This was the second SN visit, with the first on 12/30/20. -The physical exam revealed two open wounds, and nonpitting peripheral tissue edema >=4cm on the left lower leg due to increased edema. -The SN documented the need/response/plan was to apply the lower extremity wraps 2 times a week because the cardinal manifestations of heart failure were shortness of breath and fatigue, which may limit exercise intolerance, and fluid retention, which may lead to pulmonary and or splanchnic congestion and/or peripheral edema. <p>Interview with home health Program Manager on 01/22/21 at 10:25am revealed:</p> <ul style="list-style-type: none"> -The order dated 11/04/20 for PT/OT/SN evaluations was not ever received. -On 12/22/20, while a home health nurse was at the facility, a staff member asked them to check on Resident #6 related to a decline in Resident #6's ability to complete ADLs without extensive assistance. -On 12/22/20, a screening was performed by the home health nurse and a call was made to Resident #6's physician for an order for a PT/OT/SN consult. -On 12/22/20, Resident #6's physician gave an order for a PT/OT/SN consult. -On 12/23/20, there was an evaluation completed by PT and OT with additional recommendations for SN related to Resident #6 noted having weeping edema in both lower legs and the compressions stocking not able to be worn. -The facility was responsible for faxing the order to the office or handing a copy of the order to one of the home health staff member in the facility 7 days a week, 9:00am - 5:00pm. -Their policy was to initiate an order within 48 to 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 9</p> <p>72 hours after receiving the order.</p> <p>-The order was not delayed because of Resident #6's insurance.</p> <p>Review of Resident #6's PT visit notes dated 12/23/20 revealed:</p> <p>-Resident #6 presented to PT with generalized weakness, deconditioning and a functional decline.</p> <p>-Resident #6 presented during the evaluation with lower extremity muscle weakness, impaired functional mobility and transfers, poor safety awareness and pain.</p> <p>-Resident #6 would benefit from ongoing skilled PT intervention to prevent further decline.</p> <p>Review of Resident #6's OT visit notes dated 12/23/20 revealed:</p> <p>-Resident #6 presented to OT with generalized weakness, deconditioning and a functional decline.</p> <p>-Resident #6 reported she was non-ambulatory and used a wheelchair for all mobility.</p> <p>-She received assistance with all transfers and all ADLs at baseline although she was weaker than normal with increased amount of assistance required.</p> <p>-The recommendations were as follows; continued skilled OT, focus on ADL training, home safety/setup recommendations, caregiver education, energy conservation education bilateral upper extremities help and fall prevention strategies.</p> <p>Review of Resident #6's SN visit notes dated 12/28/20 revealed:</p> <p>-Resident #6 presented to SN with lower extremity edema and inability to wear current compression stockings.</p> <p>-Resident #6 was to use a continuous weave</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 10</p> <p>stockinette until able to decrease lower edema and can fit into new compression stockings.</p> <p>Interview with the home health nurse on 01/20/21 at 11:12am revealed: -Due to the bilateral lower leg edema, Resident #6 was unable to put on her compression stockings. -She could have attended to the edema earlier and more effectively if the order was sent to the home health office earlier.</p> <p>Telephone interview with the home health nurse on 01/22/21 at 10:22am revealed: -Home health did not receive the order dated 11/04/20 for PT/OT/SN. -The only order home health received was on 12/22/20 after PT was at the facility for another patient. -Resident #6 complained to PT about not being able to do her Activities of daily living (ADLs) without requiring help. -She saw Resident #6 in 01/12/21 for the increased swelling Resident #6's legs. -If the order for SN was received on 11/04/20, then home health would have examined Resident #6's legs at least 3 times a week during their visits and the edema could have been controlled to keep wounds from developing.</p> <p>Interview with Resident #6 on 01/22/20 at 11:13am revealed: -She has CHF and that made it hard for her to complete her ADLs without help. -This had increased in the past 3 months.</p> <p>Interview with the Administrator on 01/22/20 at 2:55pm revealed: -When an order was written by the physician, it was faxed to the facility and the MA from that</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 11</p> <p>floor was to fax the orders to the home health for the referral.</p> <p>-If home health was in the facility at the time the order for the referral came through then the MA could give a copy to the home health staff.</p> <p>-The order for Resident #6 dated 11/04/20 was documented in Resident #6's progress notes dated 11/04/20 from a virtual visit from the physician.</p> <p>-She was not aware the order for Resident #6 dated 11/04/20 was not sent to home health and not initiated for almost 2 months.</p> <p>-The MA was responsible for checking the progress notes from the virtual visit just like physician order sheets and hospital discharge papers.</p> <p>Telephone interview with Resident #6's physician on 01/22/20 at 12:17pm revealed:</p> <p>-On 11/04/20 she had a virtual visit with Resident #6 and the staff reported Resident #6 required more assistance with ADLs and lower extremity edema.</p> <p>-Resident #6 confirmed having a harder time with completion of ADLs and needed more help.</p> <p>-On 11/04/20 she ordered a consult for PT/OT/SN for Resident #6 due to CHF exacerbation and decline in ability to perform ADLs.</p> <p>-She was not aware the order was not followed when it was written.</p> <p>-She was aware that Resident #6 had not received PT/OT/SN as of 12/23/20 because she received a call from home health with screening results and asking for an order.</p> <p>Telephone interview with a MA/floor supervisor on 01/25/20 at 10:18am revealed:</p> <p>-She took over as 3rd floor MA/floor supervisor 01/01/21.</p> <p>-The previous MA/floor supervisor for Resident</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 12</p> <p>#6 should have notified the the physician and faxed the order dated 11/04/20 for the PT/OT/SN evaluation to home health.</p> <p>2. Review of Resident #4's current FL2 dated 10/29/20 revealed a diagnosis of end stage renal disease (ESRD).</p> <p>Review of a physician's progress note dated 11/11/20 revealed a diagnosis of hypertension.</p> <p>Review of Resident #4's signed physician order dated 12/07/20 revealed there was an order for metoprolol tartrate (used to treat high blood pressure) 50mg take one tablet twice daily, hold before dialysis treatment.</p> <p>a. Review of Resident #4's January 1, 2021 through January 20, 2021 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol tartrate 50mg, take one tablet twice daily, at 7:00am and 7:00pm. -There was documentation Resident #4 refused metoprolol tartrate 50mg at 7:00am for six occurrences and at 7:00pm for eleven occurrences. -There was no documentation of the primary care provider (PCP) being notified of the refusals.</p> <p>Interview with the medication aide (MA)/floor supervisor on 01/25/21 at 9:09am and 01/25/20 at 10:18am revealed: -Resident #4 went to dialysis 3 days per week on Monday, Wednesday and Friday. -He usually left the facility between 8:15am and 9:15am on dialysis days, and returned between 3:30-4:00pm. -At times, Resident #4 refused to take his evening medications on dialysis days.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 13</p> <ul style="list-style-type: none"> -The MAs were responsible to notify the PCP of three consecutive refusals in a row. -The PCP was notified of the medication refusals, but the MA did not have any documentation of the refusals. <p>Telephone interview with Primary Care Physician (PCP) on 01/26/21 at 8:47am revealed:</p> <ul style="list-style-type: none"> -She was not aware of Resident #4's refusals of medications. -She expected Resident #4 to take medications as ordered. <p>Telephone interview with the Administrator on 01/22/20 at 2:55pm and 01/26/21 at 1:13pm revealed:</p> <ul style="list-style-type: none"> -She was unaware that Resident #4's metoprolol in January 2021 was being refused. -The facility policy for refusals was to report the refusal to the MA/floor supervisor, document in the resident's record and notify the physician after 3 refusals in a row. -There was no documentation of notification of the PCP regarding Resident #4's refusals. -The MAs were responsible for monthly audits of the eMARs related to refusals. -There was no documentation of a record audit done in the past 3 months on Resident #4's record, but she "was sure it was done." <p>b. Review of Resident #4's current FL2 dated 10/29/20 revealed:</p> <ul style="list-style-type: none"> -There was an order for hydralazine 100mg (used to treat high blood pressure) take one tablet three times a day. -On dialysis treatment days, hold hydralazine 100mg if the systolic blood pressure (SBP) was less than 130 or the diastolic blood pressure (DBP) was less than 80. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 14</p> <p>Review of Resident #4's November 2020 electronic Medication Administration Record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for hydralazine 100mg one tablet three times a day, hold if the SBP was less than 130 or the DBP was less than 80 on dialysis days, at 7:00am, 12:00pm and 7:00pm. -There was documentation Resident #4 was not administered hydralazine 100mg at 12:00pm for 3 occurrences due to being at dialysis. -Resident #4's blood pressure readings from 11/01/20 through 11/30/20 ranged from 118/80 to 166/82. <p>Review of Resident #4's December 2020 eMAR from 12/01/20 to 12/08/20 revealed:</p> <ul style="list-style-type: none"> -There was an entry for hydralazine 100mg one tablet three times a day, hold if the SBP was less than 130 or the DBP was less than 80 on dialysis days, at 7:00am, 12:00pm and 7:00pm. -There was documentation Resident #4 was not administered hydralazine 100mg at 12:00pm for 3 occurrences due to being at dialysis. -Resident #4's blood pressure readings from 12/01/20 through 12/08/20 ranged from 100/58 to 149/90. <p>Review of Resident #4's signed physician order dated 12/07/20 revealed there was an order for hydralazine 50mg three times a day, hold before dialysis.</p> <p>Review of Resident #4's December 2020 eMAR from 12/09/20 to 12/31/20 revealed:</p> <ul style="list-style-type: none"> -There was an entry for hydralazine 50mg three times a day, at 7:00am, 12:00pm and 7:00pm, hold before dialysis. -There was documentation Resident #4 was not administered hydralazine 100mg at 12:00pm for 9 occurrences due to being at dialysis. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 15</p> <p>Review of Resident #4's January 2021 eMAR from 01/01/21 to 01/20/21 revealed: -There was an entry for hydralazine 50mg three times a day, at 7:00am, 12:00pm and 7:00pm, hold before dialysis. -There was documentation Resident #4 was not administered hydralazine 50mg at 12:00pm for 9 occurrences due to being at dialysis.</p> <p>c. Review of Resident #4's current FL2 dated 10/29/20 revealed there was an order for gabapentin 100mg (used to treat nerve pain) take one tablet three times a day.</p> <p>Review of Resident #4's November 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for gabapentin 100mg take one tablet three times a day at 7:00am, 12:00pm and 7:00pm. -There was documentation Resident #4 was not administered gabapentin at 12:00pm for 14 occurrences due to being at dialysis.</p> <p>Review of Resident #4's December 2020 eMAR revealed: -There was an entry for gabapentin100mg take one tablet three times a day at 7:00am, 12:00pm and 7:00pm. -There was documentation Resident #4 was not administered gabapentin at 12:00pm for 15 occurrences due to being at dialysis.</p> <p>Review of Resident #4's January 2021 eMAR from 01/01/21 through 01/20/21, revealed: -There was an entry for gabapentin100mg take one tablet three times a day at 7:00am, 12:00pm and 7:00pm. -There was documentation Resident #4 was not</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 16</p> <p>administered gabapentin at 12:00pm for 8 occurrences due to being at dialysis.</p> <p>d. Review of Resident #4's current FL2 dated 10/29/20 revealed there was an order for calcium 1250mg/500mg (used to treat indigestion) one tablet three times a day, after each meal.</p> <p>Review of Resident #4's November 2020 eMAR revealed: -There was an entry for calcium 1250mg/500mg one tablet three times a day, after each meal for indigestion at 7:00am, 12:00pm and 7:00pm. -There was documentation Resident #4 was not administered calcium at 12:00pm for 14 occurrences due to being at dialysis.</p> <p>Review of Resident #4's December 2020 eMAR revealed: -There was an entry for calcium 1250mg/500mg one tablet three times a day, after each meal for indigestion at 7:00am, 12:00pm and 7:00pm. -There was documentation Resident #4 was not administered calcium at 12:00pm for 13 occurrences due to being at dialysis.</p> <p>Review of Resident #4's January 2021 eMAR from 01/01/21 through 01/20/21, revealed: -There was an entry for calcium 1250mg/500mg one tablet three times a day, after each meal for indigestion at 7:00am, 12:00pm and 7:00pm. -There was documentation Resident #4 was not administered calcium at 12:00pm for 8 occurrences due to being at dialysis.</p> <p>Interview with the facility's contracted pharmacy provider on 01/25/21 at 8:35am revealed: -Medications that were missed due to dialysis, should be administered at the next scheduled time.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 17</p> <p>Interview with the third floor medication aide (MA)/floor supervisor on 01/25/21 at 9:09am revealed: -Resident #4 went to dialysis 3 days per week on Monday, Wednesday and Friday. -He was out of the facility from 8:15am to 4:00pm on dialysis days. -He was not in the facility during lunch time on dialysis days, so she just checked leave of absence on the eMAR.</p> <p>Telephone interview with Primary Care Provider (PCP) on 01/26/21 at 8:47am revealed: -She had been Resident #4's PCP since June 2020. -She was not aware of missed doses of medications on dialysis days. -She expected the facility to administer all medications as ordered, except the ones that were due while the resident was at dialysis. -She would get with the facility and review the medications that were due at noon on dialysis days. -The facility had not contacted her regarding medications that were missed at noon on dialysis days.</p> <p>Telephone interview with Resident #4's dialysis nurse on 01/26/21 at 9:21am revealed: -Medications that were ordered to be held prior to dialysis should be held. -He should not bring any medications with him. -She expected the resident to take the next scheduled dose of all medications when he returned to the facility.</p> <p>Telephone interview with the MA/floor supervisor on 01/26/21 at 10:15am revealed: -The PCP was notified that some medications</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 18</p> <p>were not administered while Resident #4 was at dialysis. -She did not have any documentation that the PCP was notified.</p> <p>Telephone interview with the Administrator on 01/26/21 at 1:13pm revealed: -There were no missed medication reports documented for Resident #4. -The MA should contact the pharmacy, PCP or the Administrator if they do not understand the medication orders. -Clarification orders for medications due at noon on dialysis days had not been requested by the facility.</p> <p>Attempted telephone interview with Resident #4 on 01/22/21 at 4:55pm was unsuccessful.</p>	D 273		
D 276	<p>10A NCAC 13F .0902(c)(3-4) Health Care</p> <p>10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 276	<p>Continued From page 19</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 2 of 7 sampled residents regarding an order for a urinalysis culture and sensitivity (UA C&S), complete blood count (CBC) with differential, complete metabolic panel (CMP), brain natriuretic (BNP), hemoglobin A1C (HgbA1C), and lipid panel (Resident #6), and an order for a weekly blood pressure and pulse check and an order for a CBC with differential and a CMP (Resident #1).</p> <p>The finding are:</p> <ol style="list-style-type: none"> 1. Review of Resident #6's current FL2 dated 10/29/20 revealed diagnoses included angina pectoris, heart failure, muscle weakness, dementia, and hyperlipidemia. <p>Review of Resident #6's physician progress note dated 11/04/20 revealed: -There was an order to obtain a UA C&S (a urine test used to determine if infection was present), CBC (a blood test used to evaluate the overall health and detect a wide range of disorders, including anemia, and infection), CMP (a series of blood tests that reflects body's blood chemistry), BNP (a blood test used to detect heart failure), HgbA1C (a test used to tell the average blood glucose over the past 2 to 3 months), and a lipid panel (a blood test that measures the amount of cholesterol and triglycerides in your blood). -Staff reported Resident #6 was having more frequent urination with an odor.</p> <p>Review of Resident #6's progress notes dated 11/04/20 revealed there was no documentation of the UA C&S, CBC, CMP, BNP, HgbA1C, and a lipid panel obtained or results documented.</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 276	<p>Continued From page 20</p> <p>Interview with the Administrator on 01/22/20 at 2:55pm revealed:</p> <ul style="list-style-type: none"> -The MAs were responsible for faxing the orders to the lab when they received them from the physician. -She was not aware the orders dated 11/04/20 for Resident #6 were not completed. <p>Telephone interview with Resident #6's physician on 01/22/20 at 12:17pm revealed:</p> <ul style="list-style-type: none"> -The staff reported Resident #6 was having frequent urination with odor so she ordered a UA C&S to check for a urinary infection. -She ordered the CBC because of Resident #6 was anemic and she needed to check the status of Resident #6's anemia. -An increased WBC would indicate an infection was present. -Resident #6 was taking a medication that required her to monitor potassium levels and this was why the CMP was ordered. -To little or to much potassium could affect your heart. -The CMP would also show how well the kidney and liver were working as well as blood sugar and electrolyte levels. -The BNP level would increase when heart failure gets worse and decrease as it improved. -Resident #6 had diabetes and took two medications used to treat diabetes. -She ordered the HgbA1C to check her levels because generally she would not give as much medication to control blood glucose if the HgbA1C was less than 10%. -Resident #6 took medication to to treat hyperlipidemia and the lipid panel would show the effectiveness of the medication. -The labs she ordered would determine the effectiveness of the medications she used to treat 	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 276	<p>Continued From page 21</p> <p>Resident #6. -She expected the facility to follow the orders she had written.</p> <p>Telephone interview with a MA/floor supervisor on 01/25/20 at 10:18am revealed: -She took over as 3rd floor MA/floor supervisor 01/01/21. -Before 01/01/21 the MA/floor supervisor was responsible for receiving the lab orders from the physician and faxing them to the lab and documenting in the residents care notes. -She was responsible after 01/01/21 to fax the orders from the physician to the lab but because this order was written before she took over as MA/floor supervisor the previous MA/floor supervisor was responsible and she does not know why it was not completed.</p> <p>2. Review of Resident #1's current FL2 dated 10/22/20 revealed diagnoses included dementia, hypertension and high cholesterol.</p> <p>a. Review of Resident #1's physician progress notes dated 09/30/20 revealed an order for blood pressure and pulse checks weekly.</p> <p>Review of Resident #1's progress notes during October 2020 revealed there was no documentation of Resident #1's weekly blood pressure and pulse checks.</p> <p>Review of Resident #1's October 2020 electronic Medication Administration Record (eMAR) revealed: -There was no entry for weekly blood pressure and pulse checks. -There was no eMAR documentation weekly blood pressure and pulse checks were obtained.</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 276	<p>Continued From page 22</p> <p>Review of Resident #1's physician progress notes dated 11/04/20 revealed an order for blood pressure and pulse checks weekly.</p> <p>Review of Resident #1's progress notes during November 2020 revealed there was no documentation of Resident #1's weekly blood pressure and pulse checks.</p> <p>Review of Resident #1's November 2020 eMAR revealed: -There was no entry for weekly blood pressure and pulse checks. -There was no eMAR documentation weekly blood pressure and pulse checks were obtained.</p> <p>Review of Resident #1's physician progress notes dated 12/11/20 revealed an order to continue the current plan of care.</p> <p>Review of Resident #1's progress notes during December 2020 revealed there was no documentation of Resident #1's weekly blood pressure and pulse checks.</p> <p>Review of Resident #1's December 2020 eMAR revealed: -There was no entry for weekly blood pressure and pulse checks. -There was no eMAR documentation weekly blood pressure and pulse checks were obtained.</p> <p>Review of Resident #1's physician progress notes dated 01/13/21 revealed an order to continue the current plan of care.</p> <p>Review of Resident #1's progress notes during January 2021 revealed there was no documentation of Resident #1's weekly blood pressure and pulse checks.</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 276	<p>Continued From page 23</p> <p>Review of Resident #1's January 2021 eMAR, from 01/01/21 through 01/20/21, revealed: -There was no entry for weekly blood pressure and pulse checks. -There was no eMAR documentation weekly blood pressure and pulse checks were obtained.</p> <p>Interview with the Administrator on 01/22/21 at 2:54pm revealed: -It was the responsibility of the MA/floor Supervisor to ensure that physician orders were accurate on the eMAR and implemented as written, for the residents on their assigned floor. -She did not know Resident #1's orders for weekly blood pressure and pulse checks were not implemented.</p> <p>Telephone interview with the Primary Care Physician (PCP) on 01/25/21 at 11:40am revealed she had requested the weekly pulse and blood pressure checks to determine a baseline for Resident #1.</p> <p>b. Review of Resident #1's physician progress notes dated 12/11/20 revealed: -There was an order for routine laboratory tests for a complete blood count (CBC) with differential, (a blood test used to evaluate the overall health and detect a wide range of disorders). -There was an order for laboratory tests for a comprehensive metabolic panel (CMP), (a blood test that reflects the blood chemistry and liver and kidney functions).</p> <p>Review of Resident #1's progress notes from 12/12/20 through 12/31/20 revealed there was no documentation the laboratory technician had completed a blood draw for CBC with differential or a CMP for Resident #1.</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 276	<p>Continued From page 24</p> <p>Review of Resident #1's physician progress notes dated 01/13/21 revealed: -There was an order for laboratory tests for CBC with differential and CMP. -There was documentation the physician was waiting the results.</p> <p>Review of Resident #1's progress notes from 01/01/21 through 01/20/21 revealed there was no documentation the laboratory technician had completed a blood draw for CBC with differential or a CMP for Resident #1.</p> <p>Interview with the MA/floor Supervisor on 01/22/21 at 10:54am revealed: -The MA/floor Supervisor who should have received the physician orders on 09/30/20, 11/04/20 and 12/11/20 was no longer employed by the facility. -It was the responsibility of the MA/floor Supervisor to review all orders for the residents on their floor and follow up with the physicians and the laboratory as needed. -She did not recall Resident #1's physician progress note dated 01/13/21 referring to a CBC with differential and CMP awaiting results. -If she had seen the reference to "awaiting the results" of the CBC and CMP, she would have assumed the blood work was previously taken, and the results had not been sent to the facility yet. -She did not contact the laboratory to determine if the blood work had been completed. -It was her responsibility as the MA/floor Supervisor to follow up on orders.</p> <p>Telephone interview with the PCP on 01/25/21 at 11:40am revealed she relied on the input of the staff, and the testing she ordered, to assist her in</p>	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 276	<p>Continued From page 25</p> <p>making health recommendations for Resident #1.</p> <p>Interview with the Administrator on 01/22/21 at 2:54pm revealed: -She did not know Resident #1's laboratory tests were not implemented. -She expected the MA/floor Supervisors to follow through and implement all physician orders for the residents on their floor as written by the physician. -She expected the MAs to follow up with the physician or third party provider to ensure the order has been implemented and the results were in the facility.</p> <p>Based on observations and interviews, it was determined Resident #1 was not interviewable.</p> <p>Attempted telephone interview with Resident #1's Power of Attorney (POA) on 01/25/21 at 9:20am was unsuccessful.</p>	D 276		
D 344	<p>10A NCAC 13F .1002(a) Medication Orders</p> <p>10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 344	<p>Continued From page 26</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 1 of 7 sampled residents (Resident #5) regarding an order for a medication to treat a mental health disorder and a medication for pain (Resident #5).</p> <p>The findings are:</p> <p>Review of Resident #5's current FL2 dated 08/05/20 revealed diagnoses included schizophrenia and arthritis.</p> <p>a. Review of Resident #5's FL2 dated 08/05/20 revealed there was an order for seroquel, (a medication used to treat schizophrenia), 150mg twice daily.</p> <p>Review of Resident #5's signed physician order on 11/02/20 revealed an order for seroquel 200mg every evening.</p> <p>Review of Resident #5's hospital discharge summary dated 11/23/20 revealed there was an order for seroquel 150mg twice daily.</p> <p>Review of Resident #5's November 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for seroquel 200mg to be administered at 8:00pm daily. -Seroquel 200mg was documented as administered at 8:00pm from 11/23/20 through 11/30/20.</p> <p>Review of Resident #5's December 2020 eMAR, from 12/01/20 through 12/26/20 revealed:</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 344	<p>Continued From page 27</p> <p>-There was an entry for seroquel 200mg to be administered at 8:00pm daily. -Seroquel 200mg was documented as administered at 8:00pm from 12/01/20 through 12/26/20.</p> <p>Review of Resident #5's hospital discharge summary dated 12/27/20 revealed there was an order for seroquel 150mg every morning and 200mg every evening.</p> <p>Review of Resident #5's December 2020 eMAR, from 12/28/20 through 12/31/20 revealed: -There was an entry for seroquel 200mg to be administered twice daily, at 8:00am and 8:00pm. -Seroquel 200mg was documented as administered at 8:00am from 12/28/20 through 12/31/20.</p> <p>Review of Resident #5's January eMAR from 01/01/21 through 01/20/21 revealed: -There was an entry for seroquel 200mg to be administered twice daily, at 8:00am and 8:00pm. -Seroquel 200mg was documented as administered at 8:00am from 01/01/21 through 01/20/21.</p> <p>Telephone interview with Resident #5's Primary Care Provider (PCP) on 01/25/21 at 11:40am revealed: -Resident #5 was seen by a Mental Health (MH) provider. -Any medications related to Resident #5's mental health diagnoses she did not change. -She deferred to the MH provider to review orders relating to Resident #5's mental health diagnoses. -The facility should be contacting the MH provider regarding the seroquel dosage and changes in the hospital discharge medication orders.</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 344	<p>Continued From page 28</p> <p>Telephone interview with the MH provider on 01/25/21 at 3:50pm revealed:</p> <ul style="list-style-type: none"> -Resident #5 had a diagnosis of schizophrenia and the seroquel helped to manage his symptoms. -She increased the seroquel from 150mg to 200mg in November (11/02/20) due to Resident #5's increased agitation and paranoia in the evenings. -The hospitalist may have prescribed a lower dosage of seroquel in the morning for a reason she was not aware of. -Otherwise, Resident #5's current seroquel order should be 200mg twice daily. <p>Telephone interview with the facility contracted pharmacist on 01/25/21 at 3:17pm revealed:</p> <ul style="list-style-type: none"> -Resident #5's most current seroquel order was 200mg twice a day, dated 11/02/20. -They had not received any new orders for Resident #5's seroquel since 11/02/20. <p>Interview with the Medication Aide/floor Supervisor (MA/floor Supervisor) on 01/22/21 at 10:54am revealed:</p> <ul style="list-style-type: none"> -She had taken the interim position of MA/floor Supervisor in January 2021. -The MA/floor Supervisor who should have received the discharge paperwork was no longer employed by the facility. -The hospital discharge paperwork should be sent to the PCP to review for the residents. -She had not sent any hospital discharge paper work to a resident's MH provider. -She had been trained as an MA to send hospital discharge paperwork to the PCP. -Before COVID-19, she would leave any paperwork for the physicians in their allotted box in the physician's office on the first floor. -She did not know Resident #5's seroquel order 	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 344	<p>Continued From page 29</p> <p>was changed on the hospital discharge paperwork on 11/23/20 and 12/27/20.</p> <p>-She had not seen Resident #5's hospital discharge summary from his November and December hospital visits.</p> <p>-The MA/floor Supervisors were currently going through all the residents' records to organize their information and not all the information had been filed back into the record.</p> <p>Interview with the Administrator on 01/22/20 at 2:55pm revealed:</p> <p>-The MA/floor Supervisors were responsible for following up with new medication and treatment orders that were written on the physician visit summary or hospital discharge summary for the residents on their assigned floor.</p> <p>-If the MA/floor Supervisor was not in the building, another MA/Floor Supervisor would follow through with their residents' orders.</p> <p>-They were responsible for sending new orders to the pharmacy, and if the orders came from the hospital or another agency, to send them to the PCP to review.</p> <p>-The facility contracted pharmacy entered the orders on the eMAR, and the MA/Floor Supervisors were responsible for verifying the accuracy of the eMAR entry by comparing it to the original order.</p> <p>-The order would become "active" on the eMAR after the MA/Floor Supervisor approved the entry.</p> <p>-If there was any question regarding the accuracy of an order, the PCP should be contacted for clarification.</p> <p>-She was not aware Resident #5's seroquel dosage was changed on the hospital discharge summary of 11/23/20.</p> <p>-The MA/floor Supervisor should have contacted the MH provider to obtain verification on the changed dosage.</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 344	<p>Continued From page 30</p> <p>b. Review of Resident #5's FL2 dated 08/05/20 revealed there was an order for Tramadol 50mg, a medication to treat pain, twice daily as needed for pain.</p> <p>Review of Resident #5's subsequent physician's order dated 10/16/20 revealed Tramadol 50mg two tablets every 8 hours.</p> <p>Review of Resident #5's hospital discharge summary dated 11/23/20 revealed an order for Tramadol 50mg, two tablets every 12 hours as needed for pain.</p> <p>Review of Resident #5's November 2020 electronic Medication Administration Record (eMAR) from 11/23/20 through 11/30/20 revealed: -There was an entry for Tramadol 50mg, two tablets every 8 hours, to be administered at 8:00am, 1:00pm and 8:00pm. -There was documentation Tramadol 100mg was administered at 8:00am, 1:00pm and 8:00pm from 11/24/20 through 11/30/20.</p> <p>Review of Resident #5's December 2020 eMAR from 12/01/20 through 12/27/20 revealed: -There was an entry for Tramadol 50mg, two tablets every 8 hours, to be administered at 8:00am, 1:00pm and 8:00pm. -There was documentation Tramadol 100mg was administered at 8:00am, 1:00pm and 8:00pm from 12/03/20 through 12/05/20, and 12/10/20 through 12/27/20.</p> <p>Interview with Primary Care Physician (PCP) on 01/25/21 at 11:40am revealed: -She had prescribed the scheduled Tramadol 50mg 2 tablets every 8 hours on 10/16/20 for pain related to an ulcer at the site of Resident #5's</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 344	<p>Continued From page 31</p> <p>ileostomy.</p> <ul style="list-style-type: none"> -If the ulcer had resolved, the hospital may have changed the Tramadol back to an as needed medication. -She had not received the hospital discharge summary, so she was not aware the Tramadol had been changed or why. -She would have to assess Resident #5 for pain to determine the dosage of Tramadol he should be currently taking. -She expected the facility staff to send hospital discharge orders for her residents so she could review them. <p>Interview with the Medication Aide/ floor Supervisor (MA/Floor Supervisor) on 01/22/21 at 10:54am revealed:</p> <ul style="list-style-type: none"> -She had administered medications to Resident #5 since 12/01/20. -As an MA, she administered medications as entered on the eMAR. -In January 2021 she took the interim position of MA/Floor Supervisor. -She was responsible for reviewing the orders for the residents on her floor, following up with the physician when necessary, faxing medication orders to the pharmacy and approving orders that were entered on the eMAR. -The pharmacy staff would enter orders on the eMAR, and the MA/floor Supervisor would verify the order was correct. -The MA/floor Supervisor could also enter orders on the eMAR after pharmacy hours or on weekends. -The MA/floor Supervisor who should have reviewed Resident #5's hospital discharge orders and forwarded them to the PCP was no longer employed at the facility. -She did not know why the hospital discharge orders for Resident #5 were not sent to the PCP. 	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 344	<p>Continued From page 32</p> <p>Interview with the Administrator on 01/22/21 at 2:55pm revealed: -It was the responsibility of the MA/floor Supervisors to forward all hospital discharge orders to the PCP for review. -It was the responsibility of the MA/floor Supervisor to check all new orders with the entry on the eMAR for accuracy and approve before administering the medication. -The MA/ floor Supervisor for Resident #5 was responsible for faxing the hospital discharge summary to the PCP for clarification and was no longer employed by the facility. -She did not know why the previous MA/floor Supervisor did not forward the hospital discharge summary with medications to the PCP or the pharmacy.</p> <p>Interview with Resident #5 on 01/22/21 at 1:35pm revealed: -He had experienced abdominal pain and pain at the site of his ileostomy "a few months ago." -He went to the hospital in November due to the pain and discomfort he was experiencing. -The area around the stoma had cleared and was not painful at this time. -The only symptom he was currently experiencing was lightheadedness and unsteadiness at times when he was transferring from a sitting to standing position or ambulating.</p> <p>Interview with the Administrator on 01/22/20 at 2:55pm revealed: -The MAs/floor Supervisors were responsible for monthly audits of the eMARs, treatment orders and orders for compliance, accuracy, blanks and refusals. -The MAs/floor Supervisors were to compare the orders for each resident with the eMAR entry and</p>	D 344		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 344	Continued From page 33 the pharmacy generated label on the medication blister pack or bottle. -They were also responsible for ordering any medication with 7 or less capsules/tablets in the blister pack or medication bottle. -There was no report given to her as to the completion of the cart audit task or the results of the audit. -There was no one responsible for oversight of these audits completed by the MA/floor Supervisor at the present time. -She was not sure when the cart audits had been last completed.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 7 sampled residents (Resident #6 and #4) related to not administering a potassium supplement as ordered (Resident #6) and not administering three different blood pressure medications per physician orders with parameters	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 34</p> <p>to hold medications based on vital signs and/or dialysis days (Resident #4).</p> <p>The findings are:</p> <p>1. Review of Resident #6's current FL2 dated 10/29/20 revealed diagnoses included heart failure, muscle weakness, and dementia.</p> <p>a. Review of Resident #6's current FL2 dated 10/29/20 revealed an order for potassium chloride (a medication used to replace the potassium in your body), 10mEq two times a day.</p> <p>Review of Resident #6's physician progress note dated 11/04/20 revealed there was an order to give potassium chloride 20mEq times three days.</p> <p>Review of Resident #6's November 2020 electronic Medication Administration Record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for potassium chloride 10mEq two times a day at 8:00am and 8:00pm, documented as administered 11/01/20 at 8:00am to 11/06/20 at 8:00pm. -There was an entry for potassium chloride 10mEq two times a day at 8:00am and 8:00pm, documented as discontinued 11/06/20 at 8:00am to 11/10/20 at 8:00am. -There was an entry for potassium chloride 10mEq two times a day at 8:00am and 8:00pm, documented as administered 11/10/20 at 8:00am to 11/30/20 at 8:00pm. -Resident #6 did not receive 7 out of 60 doses of potassium chloride 10mEq. <p>Telephone interview with Resident #6's physician on 01/22/20 at 12:17pm revealed:</p> <ul style="list-style-type: none"> -On 11/04/20, she had a virtual visit with Resident #6. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 35</p> <ul style="list-style-type: none"> -Resident #6 had a history of CHF and had been wearing compression stocking on her legs to help keep the swelling under control but the edema had gotten worse and she was seen on 11/04/20 for a follow-up virtual visit. -During the visit on 11/04/20 staff and Resident #6 reported Resident #6 was having bilateral lower extremity edema with occasional shortness of breath and the compression stockings were too small and needed a larger size. -She did a visual exam a saw Resident #6 had bilateral lower extremity edema and was breathing comfortably. -Resident #6 was already prescribed a diuretic twice daily and potassium chloride 10mEq twice daily. -When a resident took a diuretic for edema, it helped get rid of the excess fluid in the body but would also cause Resident #6 to lose potassium. -Resident #6 had a history of hypokalemia (low potassium). -She ordered the diuretic and increased potassium together to get rid of excessive fluid and replace the potassium at the same time. -On 11/04/21, during the visual visit she order additional doses of the diuretic 40mg times three days and additional doses potassium chloride 20mEq for three days to prevent worsening of Resident #6's Congestive Heart Failure (CHF) exacerbation and hospitalization. -Considering Resident #6 had a history of hypokalemia and CHF, along with the diuretic to treat the excessive fluid, Resident #6 was at risk for potassium depletion without the supplemental potassium orders which could lead to life threatening events such as a heart attack or cardiac arrest. -She expected the facility to follow the orders as written. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 36</p> <p>Refer to telephone interview with a MA/floor supervisor on 01/25/20 at 10:18am.</p> <p>Refer to interview with the Administrator on 01/22/20 at 2:55pm.</p> <p>b. Review of the physician progress note dated 11/04/20 revealed an order for potassium chloride 20mEq times three days.</p> <p>Review of Resident #6's November 2020 electronic Medication Administration Record (eMAR) revealed: -There was no entry for potassium chloride 20mEq times three days. -There was no documentation of potassium chloride 20mEq times three days administered. -Resident #6 did not receive 3 out of 3 doses of potassium chloride 20mEq.</p> <p>Interview with the Administrator on 01/22/20 at 2:55pm revealed she was not aware Resident #6 missed the daily order and 3 day order increase for potassium chloride.</p> <p>Telephone interview with the facility contracted pharmacist on 01/25/21 at 12:25pm revealed: -On 11/06/20, the pharmacy received an order for Resident #6 from the facility. -The order was for potassium chloride 20mEq times three days. -The order was keyed in as potassium chloride 20mEq once a day for three days and the previous potassium chloride order 10mEq two times a day was put on hold. -The facility canceled the two potassium chloride orders all together. -The facility staff have the capability to accept or reject the orders put in the eMARs by the pharmacy, according to the physician's orders.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 37</p> <ul style="list-style-type: none"> -The facility staff were responsible for the orders entered into the eMAR after the pharmacy was finished. -According to Resident #6's pharmacy profile, Resident #6 has heart failure and a history of hypokalemia. -Resident #6 took a diuretic along with potassium chloride which replenished the potassium lost as a result of taking the diuretic. -If the potassium was not replenished, it could lead to the body losing potassium. -When the body loses potassium, it could lead to weaken of the heart muscle, abnormal heart rhythm, heart attack or cardiac arrest, which in turn could be life threatening. <p>Refer to telephone interview with a MA/floor supervisor on 01/25/20 at 10:18am.</p> <p>Refer to interview with the Administrator on 01/22/20 at 2:55pm.</p> <p>2. Review of Resident #4's current FL2 dated 10/29/20 revealed a diagnosis of end stage renal disease (ESRD).</p> <p>Review of a physician's progress note dated 11/11/20 revealed a diagnosis of hypertension.</p> <p>a. Review of Resident #4's current FL2 dated 10/29/20 revealed there was an order for clonidine 0.1mg (used to treat high blood pressure) take one tablet twice daily, hold if systolic blood pressure (SBP) less than 130 or diastolic blood pressure (DBP) less than 70, heart rate less than 80.</p> <p>Review of Resident #4's November 2020 electronic Medication Administration Record (eMAR) revealed:</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

D 358	<p>Continued From page 38</p> <ul style="list-style-type: none"> -There was an entry for clonidine 0.1mg one tablet twice daily, to be administered at 7:00am and 7:00pm, hold if SBP less than 130 or DBP less than 70, heart rate less than 80. -There was documentation Resident #4 was administered clonidine 0.1mg at 7:00am for 18 occurrences when it should have been held. -There was documentation Resident #4 was administered clonidine 0.1mg at 7:00pm for 21 occurrences when it should have been held. -Resident #4's blood pressure readings from 11/01/20 through 11/30/20 ranged from 89/78 to 161/73. -Resident #4's heart rate readings from 11/01/20 through 11/30/20 ranged from 50 to 79. <p>Examples include:</p> <ul style="list-style-type: none"> -On 11/03/20 at 7:00pm Resident #4's blood pressure was 115/59 and heart rate was 68 and the clonidine should have been held but was documented as administered. -On 11/22/20 at 7:00pm Resident #4's blood pressure was 115/58 and heart rate was 72 and the clonidine should have been held but was documented as administered. <p>Review of Resident #4's December 2020 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for clonidine 0.1mg one tablet twice daily, to be administered at 7:00am and 7:00pm, hold if SBP less than 130 or DBP less than 70, heart rate less than 80. -There was documentation Resident #4 was administered clonidine 0.1mg at 7:00am for 18 occurrences when it should have been held. -There was documentation Resident #4 was administered clonidine 0.1mg at 7:00pm for 23 occurrences when it should have been held. -Resident #4's blood pressure readings from 12/01/20 through 12/31/20 ranged from 105/55 to 	D 358		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 39</p> <p>149/90.</p> <p>-Resident #4's heart rate readings from 12/01/20 through 12/31/20 ranged from 70 to 89.</p> <p>Examples include:</p> <p>-On 12/13/20 at 7:00am Resident #4's blood pressure was 116/78 and heart rate was 70 and the clonidine should have been held but was documented as administered.</p> <p>-On 12/04/20 at 7:00pm Resident #4's blood pressure was 118/63 and heart rate was 74 and the clonidine should have been held but was documented as administered.</p> <p>Review of Resident #4's January 2021 eMAR from 01/01/21 to 01/20/21 revealed:</p> <p>-There was an entry for clonidine 0.1mg one tablet twice daily, to be administered at 7:00am and 7:00pm, hold if SBP less than 130 or DBP less than 70, heart rate less than 80.</p> <p>-There was documentation Resident #4 was administered clonidine 0.1mg at 7:00am for 6 occurrences when it should have been held.</p> <p>-There was documentation Resident #4 was administered clonidine 0.1mg at 7:00pm for 3 occurrences when it should have been held.</p> <p>-Resident #4's blood pressure readings from 01/01/21 through 01/20/21 ranged from 106/56 to 155/89.</p> <p>-Resident #4's heart rate readings from 01/01/21 through 01/20/21 ranged from 69 to 86.</p> <p>Examples include:</p> <p>-On 01/03/21 at 7:00am Resident #4's blood pressure was 106/56 and heart rate was 69 and the clonidine should have been held but was documented as administered.</p> <p>-On 01/05/21 at 7:00pm Resident #4's blood pressure was 116/72 and heart rate was 76 and the clonidine should have been held but was</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 40</p> <p>documented as administered.</p> <p>Telephone interview with Primary Care Provider (PCP) on 01/26/21 at 8:47am revealed: -She was not aware of clonidine being administered when it was supposed to be held. -She expected the resident to take clonidine as ordered.</p> <p>b. Review of Resident #4's current FL2 dated 10/29/20 revealed: -There was an order for hydralazine 100mg (used to treat high blood pressure) take one tablet three times a day. -On dialysis treatment days, hold hydralazine 100mg if the SBP was less than 130 or the DBP was less than 80.</p> <p>Review of Resident #4's signed physician order dated 12/07/20 revealed there was an order for hydralazine 50mg three times a day, hold before dialysis.</p> <p>Review of Resident #4's November 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for hydralazine 100mg one tablet three times a day, hold if the SBP was less than 130 or the DBP was less than 80 on dialysis days, at 7:00am, 12:00pm and 7:00pm. -There was documentation Resident #4 was administered hydralazine 100mg at 7:00am for 1 occurrence when it should have been held. -There was documentation Resident #4 was administered hydralazine 100mg at 7:00pm for 6 occurrences when it should have been held. -Resident #4's blood pressure readings from 11/01/20 through 11/30/20 ranged from 118/80 to 166/82.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 41</p> <p>Examples include:</p> <ul style="list-style-type: none"> -On 11/09/20 at 7:00pm Resident #4's blood pressure was 130/63 and hydralazine should have been held but was documented as administered. -On 11/30/20 at 7:00am Resident #4's blood pressure was 118/80 and the hydralazine should have been held but was documented as administered. <p>Review of Resident #4's December 2020 eMAR from 12/01/20 to 12/08/20 revealed:</p> <ul style="list-style-type: none"> -There was an entry for hydralazine 100mg one tablet three times a day, hold if the SBP was less than 130 or the DBP was less than 80 on dialysis days, at 7:00am, 12:00pm and 7:00pm. -There was documentation Resident #4 was administered hydralazine 100mg at 7:00am for 1 occurrence when it should have been held. -There was documentation Resident #4 was administered hydralazine 100mg at 7:00pm for 3 occurrences when it should have been held. -Resident #4's blood pressure readings from 12/01/20 through 12/08/20 ranged from 100/58 to 149/90. <p>Examples include on 12/04/20 at 7:00pm Resident #4's blood pressure was 118/63 and the hydralazine should have been held but was documented as administered.</p> <p>Review of Resident #4's December 2020 eMAR from 12/09/20 to 12/31/20 revealed:</p> <ul style="list-style-type: none"> -There was an entry for hydralazine 50mg at 7:00am, 12:00pm and 7:00pm, hold before dialysis. -There was documentation Resident #4 was administered hydralazine 100mg at 7:00am for 6 occurrences when it should have been held. -Resident #4's blood pressure readings from 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 42</p> <p>12/09/20 through 12/31/20 ranged from 105/55 to 148/72.</p> <p>Review of Resident #4's January 2021 eMAR from 01/01/21 to 01/20/21 revealed:</p> <ul style="list-style-type: none"> -There was an entry for hydralazine 50mg at 7:00am, 12:00pm and 7:00pm, hold before dialysis. -There was documentation Resident #4 was administered hydralazine 50mg at 7:00am for 5 occurrences when it should have been held. -Resident #4's blood pressure readings from 01/01/21 through 01/20/21 ranged from 116/72 to 155/89. <p>Telephone interview with Primary Care Provider (PCP) on 01/26/21 at 8:47am revealed:</p> <ul style="list-style-type: none"> -She was not aware of hydralazine being administered when it should have been held. -The order for hydralazine that was changed in December 2020 should have been held for the morning dose and at noon if the resident was not in the facility. <p>c. Review of Resident #4's current FL2 dated 10/29/20 revealed there was an order for metoprolol tartrate 25mg (used to treat high blood pressure) take three tablets (75mg) twice daily, hold for heart rate less than 60, SBP less than 110, or DBP less than 70.</p> <p>Review of Resident #4's November 2020 electronic Medication Administration Record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for metoprolol tartrate 25mg (used to treat high blood pressure) take three tablets (75mg) twice daily, hold for heart rate less than 60, SBP less than 110, or DBP less than 70, at 7:00am and 7:00pm. -There was documentation Resident #4 was 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 43</p> <p>administered metoprolol tartrate 75mg at 7:00am for 3 occurrences when it should have been held.</p> <p>-There was documentation Resident #4 was administered metoprolol tartrate 75mg at 7:00pm for 11 occurrences when it should have been held.</p> <p>-Resident #4's blood pressure readings from 11/01/20 through 11/30/20 ranged from 89/78 to 166/82.</p> <p>Examples include on 11/26/20 at 7:00am Resident #4's blood pressure was 93/54 and heart rate was 81 and the metoprolol tartrate should have been held but was documented as administered.</p> <p>Review of Resident #4's signed physician order dated 12/07/20 revealed there was an order for metoprolol tartrate 50mg take one tablet twice daily, hold before dialysis.</p> <p>Review of Resident #4's December 2020 eMAR from 12/01/20 to 12/08/20 revealed:</p> <p>-There was an entry for metoprolol tartrate 25mg, take three tablets (75mg) twice daily, hold for heart rate less than 60, SBP less than 110, or DBP less than 70, at 7:00am and 7:00pm.</p> <p>-There was documentation Resident #4 was administered metoprolol tartrate 75mg at 7:00am for 3 occurrences when it should have been held due to blood pressure parameters.</p> <p>-There was documentation Resident #4 was administered metoprolol tartrate 75mg at 7:00pm for 3 occurrences when it should have been held due to blood pressure parameters.</p> <p>-Resident #4's blood pressure readings from 12/01/20 through 12/08/20 ranged from 115/59 to 149/90.</p> <p>Examples include:</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 44</p> <p>-On 12/06/20 at 7:00am Resident #4's blood pressure was 115/59 and heart rate was 78 and the metoprolol tartrate should have been held but was documented as administered.</p> <p>-On 12/04/20 at 7:00pm Resident #4's blood pressure was 118/53 and heart rate was 74 and the metoprolol tartrate should have been held but was documented as administered.</p> <p>Review of Resident #4's December 2020 eMAR from 12/09/20 to 12/31/20 revealed:</p> <p>-There was an entry dated 12/08/20 for metoprolol tartrate 50mg, take one tablet twice daily, hold before dialysis (7:00am dose).</p> <p>-Metoprolol tartrate was to be administered at 7:00am and 7:00pm on non-dialysis days.</p> <p>-There was documentation Resident #4 was administered metoprolol tartrate 50mg at 7:00am for 4 occurrences when it should have been held due to dialysis.</p> <p>Review of Resident #4's January 2021 eMAR revealed:</p> <p>-There was an entry for metoprolol tartrate 50mg, take one tablet twice daily, hold before dialysis (7:00am dose).</p> <p>-Metoprolol tartrate was to be administered at 7:00am and 7:00pm on non-dialysis days.</p> <p>-There was documentation Resident #4 was administered metoprolol tartrate 50mg at 7:00am for 4 occurrences when it should have been held due to dialysis.</p> <p>Interview with the facility's contracted pharmacy provider on 01/25/21 at 8:35am revealed medications that were missed due to dialysis, should be administered at the next scheduled time.</p> <p>Telephone interview with the medication aide</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 45</p> <p>(MA)/floor supervisor on 01/25/21 at 9:09am revealed Resident #4 went to dialysis 3 days per week on Monday, Wednesday and Friday.</p> <p>Telephone interview with Primary Care Provider (PCP) on 01/26/21 at 8:47am revealed: -She was not aware of metoprolol tartrate being administered when it should have been held. -The order for metoprolol that was changed in December 2020 should have been held for the morning dose and at noon if the resident was not in the facility on dialysis days.</p> <p>Telephone interview with the MA/floor supervisor on 01/26/21 at 10:15am revealed: -Medications with parameters were to be held if they were not met. -She had notified the PCP that some medications were not held prior to dialysis, but she did not have any documentation of notification. -The two other third floor MAs no longer worked in the facility.</p> <p>Telephone interview with the facility's contracted pharmacy provider's Pharmacist on 01/26/21 at 12:39pm revealed when medications were not held as ordered prior to dialysis, it would potentially put the resident at risk for hypotension (low blood pressure).</p> <p>Telephone interview with the Administrator on 01/26/21 at 1:13pm revealed: -She was unaware that Resident #4's medications were not being held prior to dialysis, or per ordered parameters. -She was not aware of the vital sign parameters or hold before dialysis requirements. -There were no medication error reports documented for Resident #4. -There was no documentation of a record audit</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 46</p> <p>done in the past 3 months on Resident #4's record, but she "was sure it was done."</p> <p>Refer to interview with the Administrator on 01/22/21 at 2:55pm.</p> <p>Refer to telephone interview with a MA/floor supervisor on 01/25/21 at 10:18am.</p> <p>_____</p> <p>Telephone interview with a MA/floor supervisor on 01/25/20 at 10:18am revealed:</p> <ul style="list-style-type: none"> -She took over as 3rd floor MA/floor supervisor 01/01/21. -Before 01/01/21 the MA/floor supervisor was responsible for receiving the orders from the physician and faxing them to the pharmacy. -The policy was for the MA and the floor supervisor to perform monthly audits each on the eMAR, eTAR and cart along with the physician's orders for accuracy and completion. -The staff who provided the monthly audits was no longer at the facility and she performed monthly audits when she was able to do so when she had time. -The MAs were responsible for monthly audits of the eMARs, eTARs and orders for accuracy and completion. <p>Interview with the Administrator on 01/22/20 at 2:55pm revealed:</p> <ul style="list-style-type: none"> -The MAs were responsible for monthly audits of the eMARs, eTARs and orders for compliance, accuracy, blanks and refusals. -The MA/floor supervisor were responsible for the same monthly audits as a secondary audit. <p>_____</p> <p>The facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner related to potassium chloride not</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 47</p> <p>administered, being withheld instead of increased for the three days resulting in the resident not receiving a total of 10 doses of potassium in 4 days which could result in hypokalemia which can lead to a heart attack or cardiac arrest (Resident #6); and related to clonidine, hydralazine and metoprolol being administered when they should have been held per physician orders, which could lead to hypotension (Resident #4). This failure was detrimental to the health, welfare and safety and constitutes a Type B Violation.</p> <p>The facility provided a Plan of Protection in accordance with G.S. 131D-34 on January 25, 2021 for this violation.</p> <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 12, 2021.</p>	D 358		
D 612	<p>10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp)</p> <p>10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.</p>	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 612	<p>Continued From page 48</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure the recommendations and guidance established by the Centers for Disease Control (CDC), The North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 related to the screening of residents who resided in the facility.</p> <p>The findings are:</p> <p>Review of the CDC guidelines for the prevention and spread of the coronavirus in long-term care (LTC) facilities revealed:</p> <ul style="list-style-type: none"> -Personnel should always wear a face mask in the facility. -Face masks should not be worn under the nose or mouth. -Social distancing should be implemented among the residents. -If COVID-19 is identified in the facility, restrict all residents to their rooms. -Actively monitor all residents at least daily for fever of equal to or greater than 100.0 Fahrenheit. -Residents with known or suspected COVID-19 should be cared for using recommended personal protective equipment (PPE) including eye protection, gloves, gown, and a N95 respirator face mask. -A surgical mask can be used if a N95 mask is not available. -Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly. -Routine cleaning and disinfection procedures 	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 612	<p>Continued From page 49</p> <p>(e.g., using cleaners and water to pre-clean surfaces prior to applying an Environmental Protection Agency (EPA) registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for coronavirus in healthcare settings.</p> <p>Review of the NC DHHS guidelines for the prevention and spread of COVID-19 in long term care facilities revealed:</p> <ul style="list-style-type: none"> -Staff should be screened for fever and respiratory symptoms prior to starting their shift. -Residents should be actively screened for fever and respiratory symptoms at least daily. -Follow current CDC guidance for testing of residents in long term care settings. -Consult with your local health department (LHD) regarding placement of residents testing positive for COVID-19. -Symptomatic residents and asymptomatic residents who test positive for COVID-19 should be cohorted in a designated location and cared for by a consistent group of designated facility staff. <p>Interviews with four residents during the initial tour on 01/20/21 between 8:30am and 10:15am revealed:</p> <ul style="list-style-type: none"> -"It had been over a month since they had their temperature taken." -"They can't remember when they had their temperature taken." -"The staff used to take their temperature every shift, but stopped about a month ago." -"They had not had their temperature taken for a while." <p>Review of the facility's infection control COVID-19 policy and procedures documentation revealed.</p>	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 612	<p>Continued From page 50</p> <ul style="list-style-type: none"> -All residents should be actively monitored for fever, dry cough and shortness of breath. -If a resident has a fever or other symptoms of COVID-19, the community should have the resident immediately wear a facemask as much of the time as possible. Isolate the resident in the designated isolation room. Use appropriate PPE (if available) when going into the room. Notify the Resident's Healthcare POA, family and/or responsible party. <p>Telephone Interview with a medication aide (MA) on 01/22/21 at 12:28pm revealed:</p> <ul style="list-style-type: none"> -The resident's temperatures were taken each shift up until about 1 month ago. -They no longer took the residents temperature every shift. -They stopped taking the residents temperatures when the previous MA's supervisor left the facility, but she did not know why they stopped. -They stopped getting a documentation sheet from the MA supervisor for the temperatures so she did not take them. -No one told her to stop taking the residents temperatures. <p>Review of the Resident Screening Binder on 01/22/21 @ 2:45pm revealed there were no resident screenings documented after 12/06/20.</p> <p>Interview with the Administrator on 1/22/21 at 2:58pm revealed:</p> <ul style="list-style-type: none"> -She had designated the Infection Control (IC) staff to print the screening documentation sheets for the residents by floor, and to distribute them to the MA/Floor Supervisor of each floor daily. -The MAs on each floor were to document the temperature and other vital signs/symptoms (cough, shortness of breath, lethargy), based on observations. 	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 612	<p>Continued From page 51</p> <ul style="list-style-type: none"> -The IC staff would then collect the forms daily and place in the Screening Binder. -She did not know the resident screening for all residents had not been completed since 12/06/20. -It was reported to her today (01/22/21) that the screening forms had not been distributed to the MAs by the MA supervisor since early December and so the MAs did not continue the screening process. -No one had made her aware that the screening was not being done. -It was the policy of the facility that resident screening with temperatures and symptoms were to be completed daily. -It was the responsibility of the IC staff to print the screening forms, distribute them to the MAs on each floor daily and collect them at the end of the day and place in their Resident Screening Binder. -She did not review the Resident Screening binder. <p>Telephone interview with the MA Supervisor (IC staff) on 01/25/21 at 9:10am revealed:</p> <ul style="list-style-type: none"> -The residents were to be screened daily with temperatures and other vital signs (Blood Pressure, Pulse and Oxygen saturation level). -It was her responsibility to print the resident screening forms and distribute to the MAs on each floor. -The MAs would report to her if there were any elevated blood pressures, temperatures or low oxygen levels. -The MAs would return them to her at the end of their shift. -She then checked the screening information and if there were no "red flags" she would enter the form in the Resident Screening binder. -She was assigned to the 3rd floor as the MA/floor Supervisor as in interim position until 	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 612	<p>Continued From page 52</p> <p>they could hire another staff person.</p> <p>-Because of her additional duties that the position demanded, she forgot to print and distribute the screening forms to the MAs. "It fell off my radar since I was so busy."</p> <p>-She did not tell the staff to discontinue the screening of residents.</p> <p>-She thought without the forms the staff did not complete the task.</p> <p>Telephone interview with the Local Health Department Infection Control Nurse on 01/25/21 at 3:51pm revealed:</p> <p>-She had told the facility they needed to be taking the resident's temperatures at least once per day if not more often.</p> <p>-The facility was told back in August 2020 to take the residents temperatures.</p> <p>-She had been the nurse who had worked with the facility during their initial outbreak status on August 24, 2020 through October 2020.</p> <p>Telephone interview with a MA on 01/25/21 at 5:10pm revealed:</p> <p>-She no longer took the residents temperatures.</p> <p>-She stopped taking residents temperatures toward the end of December 2020.</p> <p>-The previous MA Supervisor would give them a paper to put the temperatures on.</p> <p>-She did not question why they stopped taking the temperatures.</p>	D 612		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:</p> <p>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL013044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/26/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE LIVING CENTER OF CONCORD	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D912	<p>Continued From page 53 regulations.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Medication Administration.</p> <p>The findings are:</p> <p>Based on record reviews and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 7 sampled residents (Resident #4 and #6,) related to not administering clonidine, hydralazine and metoprolol per physician orders with parameters to hold medications based on vital signs and/or dialysis days (Resident #4) and not administering potassium chloride 10mEq two times a day and an order to administer potassium chloride 20mEq times 3 days (Resident #6). [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].</p>	D912		