STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNIT	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

(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 conducted an annual, follow-up, and a complaint investigation survey on May 18-19, 2021.	D 000		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes;	D 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNI	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

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D 255	Continued From page 1	D 255		

(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure an assessment and care plan was updated within 10 days following a significant change for 1 of 5 sampled residents (#2) who declined in her ambulatory status and became dependent on staff for personal care and safety.

The findings are:

Review of Resident #2's current FL2 dated 04/21/21 revealed:
-Diagnoses included dementia, frequent falls, Type II diabetes mellitus and depression.
-The Special Care Unit (SCU) was documented as the recommended level of care.
-Resident #2 was disoriented and was documented as ambulatory, with no assistive device checked.

Review of Resident #2's care plan dated 09/24/20 revealed:
-Resident #2 was sometimes disoriented, forgetful and needed reminders from the staff.
-Staff was to provide standby assistance for dressing and one person assistance for bathing.
-She was independent with toileting and needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 255	Continued From page 2 cues and reminders for grooming Review of Resident #2's SCU Resident Profile dated 02/15/21 revealed: -Resident #2 was independent with dressing, toileting and eating. -She ambulated independently with the assistance of a rollator. -She required cueing and redirection for these tasks. -Staff had to assist with bathing. There was no documentation of a subsequent assessment or care plan after 02/15/21 reflecting Resident #2's increased staff dependency for transfers, ambulation and personal care needs. Review of Resident #2's physical therapy notes dated 04/12/21 revealed: -Physical therapy was ordered upon discharge from a hospital admission dated 04/03/21 through 04/05/21, for evaluation due to a fall. -Therapy was necessitated for a significant functional decline in the resident's self care, ambulation and activities of daily living. -Resident presented with a high fall risk, impacting function and safety, with the recommendation the resident would benefit from a manual wheelchair. -Resident #2 had a mobility limitation that significantly impaired her ability in mobility related activities of daily living such as toileting, dressing and grooming. -She exhibited severely impaired safety awareness. -Previously she was a standby assist for grooming, hygiene and toileting; presently she required moderate assistance from staff for all activies of daily living except feeding.	D 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 255	Continued From page 3	D 255		

Interview with a medication aide (MA) on 05/18/21 at 9:25am revealed:
-Resident #2 was able to ambulate independently with her rollator when she first transferred from the Assisted Living community to the SCU.
-She was independent with dressing and grooming, and toileted herself, with staff providing cues and re-direction when needed in these areas.
-Presently, Resident #2 required staff assistance with transfers, dressing, and toileting, and ambulated independently and with the assistance of staff in her wheelchair.

Interview with a personal care aide (PCA) on 05/19/21 at 11:10am revealed:
-Resident #2 needed staff assistance with dressing and grooming.
-Staff encouraged her to call for assistance with transfers because she was a fall risk.
-She required staff assistance with toileting, and ambulation with her wheelchair if she was tired.
-She used to ambulate with a rollator, but in the past few months she was not steady enough to use the rollator anymore.

Telephone interview with Resident #2's family member on 05/19/21 at 3:05pm revealed:
-Resident #2 was ambulating with a rollator when she was admitted to the SCU in May of 2020.
-Since the pandemic, she had not visited the resident and did not know her ambulation status at this time.

Observation of Resident #2 on 05/18/21 at 11:25pm revealed:
-Resident #2 was in the common living room sitting on the sofa.
-Staff provided hands on assistance transferring Resident #2 from the sofa to the wheelchair and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNIT	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

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D 255	Continued From page 4 proceeded to wheel her to the dining room for lunch. Interview with the interim Resident Care Coordinator (RCC) on 05/19/21 at 3:45pm revealed: -It was the responsibility of the RCC to complete a new care plan within 10 days for any resident who had a significant change, and send the new care plan to the physician to be reviewed. -She had been in this position for less than 2 weeks and was still meeting the residents and updating their health records. -She did not know Resident #2 had a significant change in the past several months. Interview with the Administrator on 05/19/21 at 4:45pm revealed the RCC should complete a new care plan within 10 days for a resident who had a significant change in their level of care, and send the new care plan to the primary care physician to be reviewed. Attempted telephone interview with Resident #2's primary care physician on 05/19/21 at 11:17am was unsuccessful.	D 255		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up with the physician for 2 of 5 sampled	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNIT	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

(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	Continued From page 5	D 273		

residents related to a medication used to treat dry eyes (Resident #4) and an order for an anti-anxiety medication (Resident #1).

The findings are:

1. Review of Resident #4's current FL2 dated 03/19/21 revealed diagnoses included impaired memory, advanced aging, coronary artery disease and anemia.

Review of Resident #4's physician's orders revealed:
-There was an order form faxed from the facility dated 03/22/21 notifying the primary care provider (PCP) that the Restasis 0.5% was not on the FL2 and asking how the medication was to be administered.
-There was no response or order from the PCP for Restasis 0.5% from 03/22/21-05/06/21.
-There was no other orders for Restasis 0.5% from 03/23/21-05/06/21.
-There was an order dated 05/07/21 for Restasis 0.5% one drop in both eyes twice daily.

Review of Resident #4's progress notes revealed there was no documentation Resident #4's PCP or Ophthalmologist had been contacted for follow-up regarding Restasis 0.5% from 03/23-05/06/21.

Interview with Resident #4's family member on 05/18/21 at 9:36am revealed:
-Resident #4 always had complications with dry eyes and had been using Restasis 0.5% for years.
-On 03/19/21, he delivered 60 vials of Restasis 0.5% to the facility so that the resident could be administered medication for her dry eyes.
-He gave the medication to the sales manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNI	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

(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	Continued From page 6	D 273		

and thought Resident #4 was receiving her medication.
-On 05/06/21, he saw Resident #4 and it appeared that her right eye had redness and mild swelling.
-He checked with the medication aide (MA) who informed that the Restasis 0.5% was not on the medication cart.
-A nurse who worked for the facility found the medication on another medication cart, however stated that the facility did not have an order to administer the medication.
-He contacted Resident #4's Ophthalmologist who wrote an order for the Restasis 0.5%, he brought the order and additional Restasis to the facility to be administered.

Interview with the medication aide (MA) on 5/18/21 at 12:50pm revealed:
-Resident #4 did not begin receiving Restasis until May 2021.
-She did not remember Resident #4 having Restasis 0.5% on the cart for administration in March 2021 or April 2021.
-If family members brought medications to the facility without an order, MAs were responsible for giving the medication to the Nurse to follow-up and obtaining an order.
-MAs could also reached out to the PCP for an order if there was no order to administer a medication.
-She had not reached out to the PCP for an order for Resident #4's Restasis 0.5%.

Telephone interview with the previous Sales Manager on 05/19/21 at 8:50am revealed:
-She worked with Resident #4's family when she was first admitted to the facility in March 2021.
-She did not remember obtaining any medication from Resident #4's family member on 03/19/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNI	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

(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	Continued From page 7	D 273		

-She did not accept medications from family members, she would have asked the nurse to get the medication from the family member.

Interview with the Regional Operations Specialist (ROS) on 05/19/21 at 4:01pm revealed:
-She was a Licensed Practical Nurse/ROS who worked as a support to the clinical staff and Administrator.
-She assisted with obtaining physician's orders for the facility over the past 6 weeks.
-She was not working as the ROS when Resident #4 was admitted.
-Resident #4's family member stopped her in the lobby and was frustrated that the resident was not receiving the Restasis eye drops, but she could not remember the date.
-She found Resident #4's Restasis 0.5% on the wrong medication cart.
-She told him she would reach out to the PCP about an order for the Restasis, however the family agreed to obtain the order.
-The family member obtained the order for Restasis 0.5% on 05/07/21.
-She offered to assist the family member with obtaining the order, however he contacted the physician himself.

Telephone interview with the Medical Assistant for Resident #4's PCP on 05/19/21 at 11:10am revealed:
-Resident #4's PCP received correspondence from the facility on 03/22/21 regarding the Restasis 0.5%, however the physician did not respond.
-Resident #4's Ophthalmologist originally prescribed the Restasis 0.5% and the PCP did not write orders for the medication for the resident.
-The PCP usually expected patients to reach out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNI	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

(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	Continued From page 8	D 273		

to the original prescriber to obtain orders and refills.

Telephone interview with Resident #4's Ophthalmologist on 05/18/21 at 4:00pm revealed:
-Resident #4 had chronic redness and irritation to her left lower lid and was blind in her left eye.
-Resident #4 suffered from dry eyes and the Restasis 0.5 was prescribed to treat the dryness.
-She received a message from the resident's family member requesting an order for Restasis 0.5%.
-She faxed the order to the pharmacy on 03/17/21 for Restasis 0.5% to be administered to both eye twice daily.
-She expected Restasis 0.5% to be administered for dry eyes, however the resident's eye redness and irritation was chronic.
-She had not received any communication or correspondence from the facility from 03/19/21-05/18/21 regarding Resident #4's Restasis.
-Resident #4's family member had been the primary contact for obtaining the order for Restasis.
-Had the facility reached out to her, she would have faxed the order to the facility.

Interview with the Regional Nurse on 05/19/21 at 3:36pm revealed:
-She worked at the facility as the Regional Nurse and had not been regularly working in the facility in March 2021 when Resident #4 was first admitted.
-When family members brought in medications from the pharmacy without an order, she expected the MA or the facility Nurse to reach out to the PCP via telephone or fax to obtain an order for the medication.
-She expected the MA or Nurse to call daily until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNIT	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

(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	Continued From page 9	D 273		

an order was received and if not obtained, the MAs should document in the progress notes.

Interview with the Administrator on 05/19/21 at 4:41pm revealed:
-She expected MA and the Nurse to obtain an order for medications before they are administered.
-She expected the MAs or Nurse to reach out to the facility daily until an order is received.
-She did not remember Resident #4's family discussing the Restasis order with Resident #4's family member.

2. Review of Resident #1's current FL2 dated 08/19/20 revealed diagnoses included vascular dementia, hypertension, anxiety, macular degeneration, and osteoarthritis.

Review of Resident #2's Mental Health Provider (MHP) Consultation Notes dated 04/19/21 revealed:
-A physician's order to start Ativan 0.5mg daily at 6:00pm.
-The MHP had sent an electronic prescription to the facility's contracted pharmacy.

Review of Resident #1's medication administration record (MAR) for April 2021 revealed:
-There was an entry for Ativan 0.5mg daily at 6:00pm to start on 04/22/21.
-There was no documentation Resident #1 was administered the Ativan 0.5mg daily at 6:00pm from 04/22/21 to 04/30/21.
-There was no documented reason Resident #1's Ativan 0.5mg was not administered.

Review of Resident #1's medication administration record (MAR) for May 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNIT	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

(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	Continued From page 10	D 273		

revealed:
-There was an entry for Ativan 0.5mg daily at 6:00pm.
-There was no documentation Resident #1 was administered the Ativan 0.5mg daily at 6:00pm from 05/01/21 to 05/13/21.
-There was no documented reason Resident #1's Ativan 0.5mg was not administered.

Review of Resident #1's progress notes and the facility's 24-hour communication log revealed no documentation Resident #1 was not administered Ativan 0.5mg since 04/19/21.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/19/21 at 10:45am revealed:
-The order for Ativan 0.5mg was entered into Resident #1's pharmacy profile after the pharmacy received a copy of Resident #1's MHP visit note on 04/19/21.
-The facility reached out to the pharmacy on 04/22/21, and 05/02/21 to request an explanation for why the Ativan 0.5mg was not dispensed.
-The pharmacy representative informed the callers in order to dispense the Ativan 0.5mg the MHP needed to send the pharmacy a hard script.
-Twenty-eight tablets were dispensed to the facility on 05/12/21 when the pharmacy received an electronically generated physician's order from Resident #1's MHP.
-Resident #1's Ativan 0.5mg was a new medication prescribed by her MHP and the facility was responsible for obtaining a hard script for the pharmacy.

Interview the medication aide (MA) on 05/18/21 at 3:30pm revealed:
-On 05/13/21 she began administering Resident #1's Ativan 0.5mg when it was available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNIT	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

(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	Continued From page 11	D 273		

-On 04/22/21 and 05/02/21 Resident #1's Ativan 0.5mg was not available to be administered so she informed the Wellness Secretary.
-She did not contact the pharmacy or Resident #1's MHP because she was told by the facility nurse who provided her MA training the Wellness Secretary was responsible for contacting Resident #1's MHP or the pharmacy to follow up on orders for controlled substances.

Interview with the Wellness Secretary on 05/19/21 at 8:15am revealed:
-She attempted to reach out to Resident #1's MHP beginning on 04/22/21 when the Ativan 0.5mg was not available.
-On 04/22/21, 05/02/21 and 05/12/21 she was informed by the MA that Resident #1 had not received her Ativan 0.5mg.
-On 04/22/21 and 05/02/21 she reached out via facsimile and email to Resident #1's MHP but did not follow up with the MAs to check if Resident #1 was administered the Ativan 0.5mg.
-On 05/12/21 she reached out via facsimile and email to Resident #1's MHP and the Ativan 0.5mg was successfully delivered.
-She did not inform Resident #1's MHP that Resident #1 had not received the Ativan 0.5mg since it was prescribed on 04/19/21.

Interview with Resident #1's MHP on 05/19/21 at 11:34am revealed:
-On 04/19/21 she prescribed Ativan 0.5mg to relieve Resident #1's symptoms of sundowning related to dementia.
-On 04/22/21 she was contacted by the facility when they did not initially receive the medication from the pharmacy.
-She researched the initial electronic prescription she sent after her visit with Resident #1 on 04/19/21 and discovered she sent it to the wrong

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNIT	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

(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	Continued From page 12	D 273		

pharmacy.
-On 04/22/21 she resent the prescription to the correct pharmacy.
-On 05/11/21 she received a request via facsimile for another prescription to be sent to the pharmacy.
-She was not notified that Resident #1 was not getting her Ativan 0.5mg since 04/19/21.
-She expected the facility to contact her immediately and follow her instructions so she could assist them.
-She had not been notified Resident #1 was showing any signs of any increased agitation or anxiety that would be a concern since Resident #1 did not get the Ativan 0.5mg.

Interview with the Regional Nurse on 05/19/21 at 3:41pm revealed:
-The MAs were expected to contact the pharmacy or the physician who wrote the order if the medication was not available daily until the medication was delivered.
-There was not a process in place to make sure the residents' physicians were informed when a resident did not receive their medications.

Interview with the Administrator on 05/19/21 at 4:45pm revealed:
-She expected the MAs to document in the communication book when a resident's medication was not available for administrations.
-When she became aware of issues with residents not receiving their medications, she informed the clinical staff such as the RCD, assistant RCD, and the Facility Nurse.
-Since the RCD, assistant RCD, and the Facility Nurse quit she was informed there were breaks in communication among the clinical staff.
-Currently the Regional Operations Specialist was assisting the facility until new staff would be hired

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNIT	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

(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	Continued From page 13 to replace the RCD, assistant RCD and Facility Nurse.	D 273		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide a five-day report to Health Care Personal Registry (HCPR) for alleged abuse to Resident #1. The findings are: Review of the facility's Abuse, Neglect, and Exploitation Prohibition and Prevention Policy dated 09/01/19 revealed: -Reporting requirements included reporting to state agencies. -Notices to state agencies are submitted per requirements (e.g. fax, email, special carrier, mail, or telephone. -A report of the investigation is provided to the appropriate state agency with five working days of the incident, unless otherwise indicated by state law or regulation. -Copies of the written report to the state agency, and any documents created as part of the investigation are maintained. Review of Resident #1's current FL2 dated 08/19/20 revealed:	D 438		

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D 438	Continued From page 14	D 438		

-Diagnoses included vascular dementia, hypertension, anxiety, macular degeneration, and osteoarthritis.
-The Special Care Unit (SCU) was documented as the recommended level of care.
-Resident #1 was intermittently disoriented.

Review of Resident #1's HCPR Initial Allegation Report dated 03/26/21 revealed:
-Resident #1's allegation of abuse was reported to the Administrator on 03/26/21.
-A team member reported Resident #1 was struck by a staff member.
-The team member was not sure of details of the incident.
-The team member was not a witness of the abuse only informed by someone who witnessed the incident when it occurred.
-The report was signed and dated 03/26/21 by the Administrator.

Review of Resident #1's HCPR five-day Allegation Investigation Report dated 04/01/21 revealed:
-On 03/26/21 at 1:45pm the facility opened and investigation.
-Through interview with staff Resident #1 was not struck but the accused roughly removed a teddy bear from Resident #1's lap then proceeded to aggressively strike and taunt Resident #1 with the teddy bear multiple time in the chest area.
-The incident occurred on 03/19/21 and was not timely reported by three staff who witnessed the incident.
-Full assessment of Resident #1 for injury or signs of harm revealed to signs of injury, skin intact, and no bruising.
-Resident #1's assessment for mental anguish revealed Resident #1's was diagnosed with dementia and Resident #1's was not a good

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D 438	Continued From page 15	D 438		

historian however did not appear to be in any mental distress.
-Corrective actions by the facility following the incident's five-day investigation was termination of three staff who witnessed the incident and the accused staff.
-The report was signed and dated 04/01/21 by the Administrator.

Telephone interview with a HCPR investigator on 05/18/21 at 4:23pm revealed:
-She received an initial allegation report on 03/26/21 via fax from the Administrator.
-She telephoned the Administrator on 04/13/21, 04/21/21, and 05/10/21.
-She provided detailed messages requesting a five-day report, and a return telephone call from the Administrator.
-She had not received the five-day report or a return telephone call to discuss the allegation of abuse.

Interview with the Administrator on 05/18/21 at 11:15am revealed:
-On 03/26/21, she completed Resident #1's Initial Allegation Report and faxed the report to the HCPR investigator.
- On 04/01/21, she completed Resident #1's five-day investigation report and faxed the report to the HCPR investigator.
-She did not have copies of the faxed documents to prove confirmation these documents were received by the HCPR investigator.
-She received telephone messages from staff that the HCPR investigator requested a return telephone call in reference to a HCPR five-day report, but she could not recall the dates.
-The messages left by the HCPR investigator contained no information regarding which allegation she was requesting a return telephone

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D 438	Continued From page 16 call to discuss. -There was another HCPR investigation she was working on since January 2021 and she needed clarification from the HCPR investigator for Resident #1. -On 05/10/21, she attempted to contact the HCPR investigator and left her a message to return her call with more details about the five-day report. -She did not know the HCPR investigator did not receive the five-day report. -When the HCPR investigator left messages for her, the messages did not provide enough detailed information to allow another person in her absences to send the HCPR five-day report. Interview with the Administrator on 05/19/21 at 4:45pm revealed: -She could not locate a copy of the fax confirmation Resident #1's HCPR five-day investigation report. -She had not attempted to resend Resident #1's HCPR five-day investigation report at this time since 04/01/21 because she did not know it was necessary.	D 438		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served.	D 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 463	Continued From page 17 (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2, and #3) admitted to the Special Care Unit (SCU) had disclosures information regarding policies and procedures in the SCU. The findings are: 1. Review of Resident #1's current FL2 dated 08/19/20 revealed: -Diagnoses included vascular dementia. -The Special Care Unit (SCU) was documented as the recommended level of care. -Resident #1 was intermittently disoriented. Review of Resident #1's record revealed there was no documentation that a disclosure regarding policies and procedures in the SCU was provided to and signed by the family members. Telephone interview with Resident #1's responsible family member on 05/19/21 at 12:20pm revealed she could not recall if	D 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 463	Continued From page 18	D 463		

disclosure information or a document with the information was presented to her regarding Resident #1's admission to the SCU.

Refer to the interview with the Business Office Manager on 05/19/21 at 2:40pm.

Refer to the interview with the Wellness Secretary of the SCU on 05/19/21 at 3:12pm.

Refer to the interview with the Administrator on 05/19/21 at 4:45pm.

2. Review of Resident #2's current FL2 dated 04/21/21 revealed:
-Diagnoses included dementia, frequent falls, Type II diabetes mellitus and depression.
-The Special Care Unit (SCU) was documented as the recommended level of care.
-Resident #2 was disoriented.

Review of Resident #2's progress notes revealed an admission date to the SCU on 05/13/20 from the Assisted Living community.

Review of Resident #2's record revealed:
-There was no documentation of a pre-admission screening prior to admission to the SCU.
-There was no documentation a disclosure regarding policies and procedures in the SCU was provided to and signed by the family members or the guardian.

Resident #2's SCU disclosure documentation was requested on 05/18/21 at 4:55pm and on 05/19/21 at 9:30am and was not provided prior to survey exit.

Attempted telephone interview with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 463	Continued From page 19	D 463		

responsible family member on 05/19/21 at 3:00pm was unsuccessful.

Refer to the interview with the Business Office Manager on 05/19/21 at 2:40pm.

Refer to the interview with the Wellness Secretary of the SCU on 05/19/21 at 3:12pm.

Refer to the interview with the Administrator on 05/19/21 at 4:45pm.

3. Review of Resident #3's current FL2 dated 07/15/20 revealed:
-Diagnoses included Alzheimer's dementia, benign prostatic hyperplasia (enlargement of the prostate gland), high blood pressure, stroke, organic brain syndrome, hyperlipidemia (elevated fat levels in the blood) and coronary artery bypass graft.
-The Special Care Unit (SCU) was documented as the recommended level of care.
-Resident #3 was intermittently disoriented.

Review of Resident #3's record revealed there was no documentation of a disclosure regarding policies and procedures in the SCU was provided to and signed by the family members or the guardian.

The SCU disclosure was requested on 05/18/21 at 4:55pm and 05/19/21 at 9:30am from the Administrator and was not provided prior to survey exit.

Refer to the interview with the Business Office Manager on 05/19/21 at 2:40pm.

Refer to the interview with the Wellness Secretary of the SCU on 05/19/21 at 3:12pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 463	Continued From page 20 Refer to the interview with the Administrator on 05/19/21 at 4:45pm. _____ Interview with the Business Office Manager (BOM) on 05/19/21 at 2:40pm revealed: -She kept a resident file for information pertaining to billing and some admission criteria. -The Marketing manager would provide her with all the admission information that was signed by the resident or the responsible family member to be included in the resident's file. -She did not know if the Special Care Unit (SCU) disclosure statements were included in the resident files. -She was not able to locate Resident #2's disclosure statements in the resident's file. Interview with the Wellness Secretary of the SCU on 05/19/21 at 3:12pm revealed: -She assisted the Resident Care Coordinator (RCC) in completing some of the necessary paperwork for the SCU residents. -It was the responsibility of the Wellness Nurse and the RCC to ensure all the documentation required was in the resident record. -It was the responsibility of the RCC to assist families and residents with the admission paperwork. -There was currently a vacancy in the RCC and Wellness Nurse positions. -She did not review the SCU disclosure information with the resident's responsible party. Interview with the Administrator on 05/19/21 at 4:45pm revealed: -She did not realize SCU disclosure information was not being provided to the residents' family members or the guardian in the SCU. -She expected all residents' family members or	D 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 463	Continued From page 21 the guardians of the resident residing in the SCU be provided disclosure information prior to being admitted directly to the SCU or transferred from the Assisted Living community to the SCU. -It was the BOM and her responsibility to make sure disclosure information was provided. -There was not a system in place to audit the residents' records to make sure the disclosure information was provided prior to them being admitted to the SCU.	D 463		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the	D935		

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D935	Continued From page 22 individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the completion of the 5, 10, or 15-hour medication aide training for 1 of 5 sampled staff (Staff A) who administered medication. The findings are: Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A's date of hire was 02/17/21. -There was documentation Staff A was competency validated for medication administration clinical skills on 03/04/21. -There was documentation Staff A passed the medication aide test on 12/12/18. -There was no documentation Staff A had completed the state approved 15-hour training. Review of an electronic Medication Administration Record (eMAR) revealed Staff A administered medication 05/18/21.	D935		

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D935	Continued From page 23 Interview with Staff A on 05/19/21 at 4:41pm revealed: -She was the MA assigned to administer medications in the special care unit (SCU) for second shift on 05/19/21. -She received MA training and passed the test in December 2018. -She had administered medications to residents at the facility since February 2021. -She did not remember ever completing the 5, 10, or 15-hour medication aide training. -She used her previous experience from administering medications at another facility. Interview with the Business Office Manager (BOM) on 05/19/21 at 5:25pm revealed: -She was responsible for maintaining all employee records. -She could not find the medication aide training for Staff A. -The previous Resident Service Director (RSD) was responsible for maintaining the training for the MAs. -The previous RSD would give me a copy of the training to include in the staff personnel record. -She did not have had a checklist she referenced for necessary training and certifications for all staff. -She relied on the RSD to provide all required training documentation for MAs. -The former RSD was responsible for ensuring the MA training was completed and they were to be stored in the office. -She was not sure who was responsible for ensuring MA training, clinical skills, or test requirements for MAs now the RSD is no longer working for the facility. Interview with the Administrator on 05/19/21 at 4:50pm revealed:	D935		

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D935	Continued From page 24 -The BOM was responsible for maintain employee records. -The BOM was responsible maintaining all the MA training for MAs. -She did not know Staff A did not have MA training in her staff record. -She expected the BOM to make sure all staff training was in their personnel record before they were hired.	D935		