Received via email on 04/11/23.

PRINTED: 03/28/2023
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNITY	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 and the Mecklenburg County Department of Social Services conducted an annual and follow-up survery on March 7, 2023 through March 9, 2023.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Resident #4) who required assistance with toileting and had a history of falling. The findings are: Review of the facility's fall management and investigating policy dated 09/01/18 revealed: -All residents were to have a fall risk assessment completed upon admission. -After the resident experienced a fall, their service plan/care plan was to be reviewed and revised. -The changes made to the service plan/care plan were to be communicated to the staff, resident, and family. -Fall interventions were to be reviewed for continued effectiveness.	D 270	ED or Designee to complete post fall investigation within 24 hours of resident fall. DRC or Designee to review care plan of resident post fall and document new intervention every 30 days. DRC or Designee to complete post fall huddles to discuss resident's current incident, interventions and education every 30 days. DRC or Designee to docuent new intervention on care plan post fall	4/23/23

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 4/7/23

STATE FORM 6899 JC6H11 If continuation sheet 1 of 26

Reviewed and acknowledged on 04/20/23 by Jennifer Fender, RN / jbf

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D 270	Continued From page 1 -Fall interventions were to be communicated to staff, family and resident for safety awareness and the risk and benefits of fall prevention. -Falls were to be investigated, reported, and documented, using root cause analysis concepts. -The Administrator was responsible for instituting/commencing the investigation process. -A careful review and analysis of the possible contributing factors to the fall with or without injuries was to be completed using QAPI (Quality Assurance and Performance Improvement) program Post Fall Investigation form. -The Resident Care Director (RCD), or designee, was to analyze the results for trends and patterns in resident falls to use as the basis for implementation of process improvement. -Result and process improvement plans were to be reviewed; a trend analysis included, but not limited to the following: a review of the QAPI Post Fall Evaluation; comparison of the Fall Risk score; analysis of the data and determination of causal factors if possible; identification of the time day, day when the fall happened; review of the staffing pattern; consideration of the location of the fall; and follow-up evaluation of the effectiveness of each action plan the "At Risk" meeting. Review of the facility's Post-Fall Observational Review Guidelines for Unlicensed Team Members dated 04/22/20 revealed: -The observational review was to be performed after an unwitnessed fall or a fall in which a resident hits their head and completed when there were no licensed team members on duty. -The completed tool was to be kept in the resident's record. -Observational reviews were performed immediately upon finding the resident, every 30 minutes after times 2, every two hours times 2,	D 270	ED or Designee to complete QAPI and review post fall checklist every week and discuss with leadership team during weekly IDT meetings. Unlicensed Team Members or Designee will complete Post Fall Observational Review for unwitnessed falls and head injuries for residents that remain in the community. Post Fall Observational Review to be reviewed by DRC, ADRC, or Designee daily for completion and follow up.	4/23/23

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D 270	Continued From page 2 and then every 8 hours times three. Observation of Resident #4's room in the Special Care Unit (SCU) on 03/09/23 at 10:00am revealed it was located approximately 60 feet from the nurse's station and required two turns down the hallway to the right. Review of Resident #4's current FL2 dated 01/02/23 revealed diagnoses included atrial fibrillation, communication deficit, Lewy body dementia, congestive heart failure, muscle weakness, pacemaker and valve replacement. Review of Resident #4's care plan dated 12/29/22 revealed: -He required supervision with eating, grooming and transfers. -He required limited assistance with ambulation. -He required extensive assistance with dressing. -He was totally dependent with toileting. Review of Resident #4's licensed health professional support (LHPS) evaluation dated 02/08/23 revealed he required staff assistance with transfers. Review of Resident #4's January 2023 - March 2023 progress notes revealed: -On 01/06/23, at 9:30pm, a medication aide (MA) documented, Resident #4 was found in his bed during a medication pass around 9:25pm with a bloody head and face. -Resident #4 stated he fell in the bathroom and hit his head on the floor. -Resident #4 was transported to the hospital after his fall. -On 01/10/23, at 10:48pm, a MA documented Resident #4 was found on the floor close to his room around 10:20pm.	D 270		

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D 270	Continued From page 3 -Resident #4 stated he fell while going to the bathroom and complained of mild tenderness to his lower back and left hip more than his right hip. -Resident #4 was assisted back to bed after his fall. -On 01/14/23, at 11:05pm, a MA documented Resident #4 was found on the floor in his bathroom. -Resident #4 stated he slid down while trying to use the bathroom; no complaints of pain or tenderness. -On 01/20/23, at 10:00pm, a MA documented Resident #4 was found in his bed with dried blood on his head and 911 was called. -On 03/06/23, a MA documented at an unknown time, Resident #4 was found on the floor with a head injury and transported to the hospital. Review of Resident #4's incident and accident reports revealed: -On 01/06/23, at 10:00pm, Resident #4 was observed lying in his bed with blood noted to his head and face and on the floor near his bed. -Resident #4 stated he fell backwards while in his bathroom and hit his head on the floor. -Resident #4 was transported to the hospital. -On 01/10/23, at 11:20pm, Resident #4 was observed sitting on the floor in the hallway near his door with his walker beside him and his briefs below his buttocks. -Resident #4 stated that he was trying to use the bathroom and fell. -Resident #4 was not transported to the hospital. -On 01/14/23, at 11:50pm, Resident #4 was observed on his bathroom floor. -Resident #4 was unable to give a description of what happened. -Resident #4 was not transported to the hospital. -On 01/20/23, at 11:00pm, Resident #4 was observed lying in his bed with blood on his head.	D 270		

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D 270	Continued From page 4 -Resident #4 was unable to give a description of what happened. -Resident #4 was transported to the hospital. -On 03/06/23, at 7:00am, Resident #4 was observed sitting on the bedroom floor with a bruise noted to the back of his head on the right side. -Resident #4 was transported to the hospital. Review of Resident #4's January 2023 - March 2023 Emergency Room visit notes revealed: -On 01/06/23, Resident #4 was diagnosed with a head injury due to a fall and required a follow-up with his primary care physician (PCP) by 01/24/23. -On 01/20/23, Resident #4 was diagnosed with a head injury from a fall and required a follow-up within 3 days with his PCP. Review of Resident #4's January 2023 - March 2023 Fall Risk Assessment forms revealed: -On 01/05/23, Resident #4 scored 80, which was higher than 45, and deemed him as a high risk of falls. -The plan of care to minimize his risk of falls; was to remind him to use his assistive devices; staff would provide him a safe environment, clutter free, ensure assistive devices were available and in good repair, and within reach; staff would ensure he wore appropriately fitting clothes and foot wear when he was ambulating or in motion. -On 01/05/23, there was no documentation on the computerized task for safety interventions. -On 01/07/23, Resident #4 scored 80, which was higher than 45, and deemed him as a high risk of falls. -The plan of care to minimize his risk of falls; was to remind him to use his assistive devices; staff would provide him a safe environment, clutter free, ensure assistive devices were available and	D 270		

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D 270	Continued From page 5 in good repair, and within reach; staff would ensure he wore appropriately fitting clothes and footwear when he was ambulating or in motion. -On 01/07/23, there was no documentation on the computerized task for safety interventions. -On 01/13/23, Resident #4 scored 80, which was higher than 45, and deemed him as a high risk of falls. -The plan of care to minimize his risk of falls; was to remind him to use his assistive devices; staff would provide him a safe environment, clutter free, ensure assistive devices were available and in good repair, and within reach; staff would ensure he wore appropriately fitting clothes and footwear when he was ambulating or in motion. -On 01/13/23, there was no documentation on the computerized task for safety interventions. -On 03/08/23, Resident #4 scored 80, which was higher than 45, and deemed him as a high risk of falls. -The plan of care to minimize his risk of falls; was to remind him to use his assistive devices; staff would provide him a safe environment, clutter free, ensure assistive devices were available and in good repair, and within reach; staff would ensure he wore appropriately fitting clothes and footwear when he was ambulating or in motion; and staff would remind him to rise and change positions slowly. -On 03/08/23, there was no documentation on the computerized task for safety interventions Review of Resident #4's Post-Fall Observational Review Checklist for Unlicensed Team Members revealed there were no checklist completed for Resident #4 after every fall. Interview with the Assistant Resident Care Director (ARCD) on 03/08/23 at 9:30am and 3:14pm revealed:	D 270		

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D 270	Continued From page 6 -After a resident fell the MA was responsible for completion of the Incident/Accident (I/A) report. -The Health and Wellness Director (HWD) was responsible for entering the I/A report into the computer. -The I/A report generated a new fall risk assessment with interventions that were populated or could be generated with new interventions. -The fall risk assessment interventions could be changed by the HWD. -She, the HWD and the RCD were responsible for meetings with the staff after the falls to discuss what happened and ways to help prevent the falls. -She was aware of all of the falls Resident #4 received but because she was in the new position, there were no meeting as of 03/08/23. -She and the RCD were responsible for review of all of the I/A reports after each fall. -The Administrator was responsible for completing the QAPI root cause analysis with each fall to be used during the falls management meetings and care planning. -The Administrator was new and the QAPI was not used. -Routine resident checks in the SCU were conducted every hour. -There were no recommendations implemented by the facility after a resident fell. -There was no paperwork available for the staff to use to document increased rounding/checks in the SCU or the facility. Interview with the RCD on 03/08/23 at 9:35am revealed: -The MA was responsible for completing the I/A report after every fall. -The HWD was responsible for the input of the I/A report information into the computer.	D 270		

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D 270	Continued From page 7 -She was aware of all Resident #4's falls. -There was supposed to be a post fall meeting with the staff and management after every fall to discuss the fall. -She and the ARCD were responsible for reviewing the I/A reports after every fall before the post fall meetings. -She was not aware the meetings were not completed after every fall with staff, ARCD and HWD. -Routine checks on residents in the SCU were conducted every hour. -The staff was responsible for completing the rounding checklist every hour and she could not modify the checklist. -The form did not allow for modification to every 30 minutes or less supervision. -She did not know the facility had a 30-minute round form or a Post Fall Observation Checklist form to fill out after every fall. -The ARCD was responsible for auditing all fall reports daily, and she was responsible for auditing them on a weekly basis to make sure there were new recommendations in place to help prevent falls, but with new staff and changes in staff responsibilities, those audits were not conducted since 01/01/23. Telephone interview with a second shift MA on 03/08/23 at 11:20am revealed: -Resident #4 had a fall on 01/06/23, and a second fall the next week later in the evening. -Resident #4's falls were usually unwitnessed, happened after 9:00pm, included a head injury, and were related to using the bathroom. -There was no facility policy to check on a resident more than every hour and there were rounding/checklist forms the staff filled out every hour.	D 270		

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D 270	Continued From page 8 Telephone interview with another second shift MA on 03/08/23 at 11:32am revealed:. -Routine resident checks in the SCU were completed every hour. -Resident #4 fell in January 2023 later in the evening and hit his head. -There were no increased supervision of Resident #4 after the fall or when he returned from the hospital. -The MAs were responsible for initiating the increased rounding sheet and the personal care aide (PCA) was responsible for completing the rounding sheet. Interview with the HWD on 03/08/23 at 12:22pm revealed: -Routine resident checks for SCU were conducted every hour. -The PCAs were responsible for completing the hourly rounding sheets every day. -The staff only complete hourly rounding and did not increase rounding based upon falls, returning from the hospital or behaviors. -The staff were responsible for hourly checks to monitor the resident for changes in mental status, increased pain, or anything out of the abnormal and then document in the resident's notes and notification to her as well as the PCP or 911 if necessary. -Resident #4's interventions since he was admitted on 01/05/23, were to keep him "in-sight" except when he was in bed and to increase his bathroom visits. -There was no documentation or reports used to document the number of times Resident #4's briefs were changed or assisted to the bathroom. -After Resident #4 had a fall there was to be a care plan meeting. -The post-fall care plan meeting was never held because there were new staff in the management	D 270		

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D 270	Continued From page 9 positions and Resident #4 was admitted on 01/05/23. Interview with a PCA on 03/08/23 at 12:30pm revealed: -She completed routine rounding/checks on residents in the SCU every hour. -She was aware Resident #4 fell many times and she was not directed to increase supervision by the MAs, ARCD or the HWD. -The routine resident checks sheet only allowed for every hour checks. -There was no post-fall staff meeting related to residents who fell in the SCU. Telephone interview with Resident #4's PCP on 03/09/23 at 10:00am revealed: -On 01/10/23, he saw Resident #4 as a new patient and a follow-up visit from a recent hospitalization for a fall prior to admission to the facility. -On 01/10/23, Resident #4 was at high risk for falls and after the first fall at the facility on 01/06/23 he ordered physical therapy to evaluate and treat due to weakness, gait issues and high fall risk. -On 01/10/23, he also he instructed the staff to move Resident #4 closer to the nurses station and to monitor Resident #4 every 30 minutes. -He reminded staff every Tuesday when he was in the facility to increase the supervision to the residents who have fallen to every 30 minutes and more frequent if necessary. -He expected the facility to increase the supervision of Resident #4 from every hour to every 30 minutes and more if needed because due to Resident #4's history of dementia, and coumadin, Resident #4 was at risk for increased falls, increased chance of hitting his head which could lead to a brain bleed which could increase	D 270		

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D 270	Continued From page 10 the risk of death from the brain bleed. -After a head injury, the staff should be monitoring Resident #4 every 30 minutes or more for changes in mental status because it could also be an urinary tract infection and that could increase the risk of falls or worsening of the head injury. -It was his understanding Resident #4's falls were happening after 9:00pm while trying to get to the bathroom. -Resident #4 required total assistance with toileting and therefore the staff should have increased supervision to include more frequent bathroom visits to decrease the chance of a fall and injury. Observation during the interview with the Administrator on 03/09/23 at 11:05am revealed he was given a copy of the facility's fall management and investigating policy dated 09/01/18. Interview with the Administrator on 03/09/23 at 10:52am revealed: -The facility did not have a written policy about increasing supervision that he was aware of until the Regional Nurse gave him a copy of the facility's fall management and investigating policy dated 09/01/18. -When a fall happened, the MA was responsible for completing the I/A report. -The HWD was responsible for entering the I/A report into the computer. -A new fall assessment was generated when the I/A report was entered into the computer. -With the new fall assessment the computer generated basic implementations to follow and the HWD was expected to enter increased supervision as a new implementation. -He was not aware of any interventions put in	D 270		

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D 270	Continued From page 11 place for Resident #4 after each of his falls. -He did not know about the QAPI report because he was new to this community. -When a resident required increased supervision, the RCD, HWD and ARCD were responsible for a care plan meeting and to ensure the increased supervision per Resident #4's care plan. -He did not know if a care plan meeting took place and also unsure if the family was contacted about the care plan meeting. -The staff could increase supervision with the use of a third party staffing, companion sitter, staff member or a private sitter which was paid for by the facility. -He was not aware if any of those options had provided increased supervision for Resident #4. -The HWD was responsible for auditing the rounding sheets daily. -The RCD was responsible for auditing the rounding sheets for completion on a weekly basis. -He did not know if the audits were performed at all. Attempted telephone interview with Resident #4's family member on 03/09/23 at 12:40pm and 3:00pm was unsuccessful. The facility failed to provide supervision for Resident #4, in the Special Care Unit who experienced ongoing falls with head injuries since 01/05/23 which resulted in four visits to the emergency room. This failure was detrimental to the resident's health and safety and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/09/23.	D 270		

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D 270	Continued From page 12 THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 23, 2023.	D 270	DRC and Wellness Nurse completed MAR audits on 3/14/23 and reviewed current physician orders to ensure MAR accuracy.	4/23/23
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #1) related to not administering a medication used to treat indigestion, acid reflux, and heartburn. The findings are: Review of the facility's Medication Management Policy dated 04/01/19 revealed: -All medications provided to a resident are ordered, in writing, by the resident's physician/healthcare provider. -A valid physician's order must include the date, resident name, name of medication, dose, direction for use, parameters and duration. -Medication administration is documented on the Medication Administration Record (MAR) at the time the medication is provided or taken.	D 358	DRC or Designee to complete monthly MAR reviews to ensure accurate transcription and discontinuing of orders. ADRC, Wellness Nurse, or Designee to complete monthly MAR audits at the end of each month. First and Second MAR checks to be completed by ADRC and Wellness Nurse for accuracy.	4/23/23

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 03/09/2023

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

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D 358	Continued From page 13 -All medications are appropriately dispensed and labeled as per prescription for the appropriate resident. -Changes in medication orders require a label change to reflect the current prescription. Review of Resident #1's current FL2 dated 11/27/23 revealed: -Diagnoses included traumatic subdural hematoma, history of falls, congestive heart failure, chronic kidney disease stage III and atrial fibrillation. -He was intermittently confused. -There was an order for omeprazole 20mg (a medication used to treat indigestion, acid reflex and heartburn) by mouth daily. Review of Resident #1's record revealed he was hospitalized from 01/07/23 to 02/02/23. Review of Resident #1's February 2023 MAR revealed: -There was an entry for omeprazole 20mg by mouth daily. -There was documentation omeprazole 20mg was administered 02/02/23 through 02/13/23 at 8:00am. -D/C'd 02/14/23 was handwritten and highlighted on the MAR after the 02/13/23 entry as being administered. -There was no documentation from 02/14/23 through 02/28/23 of omeprazole being administered. Review of Resident #1's March 2023 MAR revealed: -There was an entry for omeprazole 20mg by mouth daily. -There was documentation of omeprazole 20mg was administered daily 03/01/23 through 03/08/23	D 358		

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D 358	Continued From page 14 at 8:00am. Observation of Resident #1's medications on hand on 03/08/23 at 4:00pm revealed a bubble pack of omeprazole 20mg by mouth daily. Review of Resident #1's Physician Orders revealed there was no order to discontinue omeprazole 20mg by mouth daily. Telephone interview with the facility's contracted Pharmacist on 03/08/23 at 10:28am revealed: -There were no orders received to discontinue omeprazole 20mg by mouth daily for Resident #1. -Potential outcome from not receiving omeprazole could lead to acid reflex especially while laying down and heartburn. Telephone interview with Resident #1's family member on 03/08/23 at 2:34pm was unsuccessful. Interview with a second shift medication aide (MA) on 03/08/23 at 4:30pm revealed: -She did not know who wrote the note to discontinue omeprazole on the February 2023 MAR. -The MAs, the Assistant Resident Care Director (ARCD) and the Resident Care Director (RCD) were all responsible for faxing medication orders to the pharmacy, clarifying medication orders, verifying the MAR was accurate and documenting orders on the MAR. -All new orders were placed in the residents' charts. -She did not remember seeing an order to discontinue omeprazole in February 2023. The ARCD was unavailable for interview on 03/09/23.	D 358		

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D 358	Continued From page 15 Telephone interview with Resident #1's Primary Care Provider (PCP) on 03/09/23 at 10:25am revealed he had not discontinued the order for omeprazole. Interview with the RCD on 03/09/23 at 11:49am revealed: -She did not know Resident #1 had not received omeprazole from 02/14/23 through 02/28/23. -She did not know Resident #1 did not have an order to discontinue omeprazole. -She did not know why someone had written on the February MAR to discontinue Resident #1's omeprazole. -The MAs, the ARCD and the RCD were responsible for faxing medication orders to the pharmacy, clarifying medication orders, verifying the MAR was accurate and documenting orders on the MAR. -All new medication orders were kept in a binder in the medication room and a copy was also placed in the residents' charts. -The ARCD was responsible for auditing the charts, medication carts, and MARs weekly. -She did not know if there was any documentation in place to document the audits. Review of the medication order binder on 03/09/23 revealed there was no order to discontinue Resident #1's omeprazole 20mg by mouth daily. Interview with the Administrator on 03/09/23 at 10:52am revealed: -He became the Administrator of the facility last week. -He did not know Resident #1 had not received omeprazole from 02/14/23 though 02/28/23. -The MAs, the ARCD and the RCD were able	D 358		

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D 358	Continued From page 16 write orders on the MAR. -The RCD and the ARCD were responsible for auditing the charts and medication orders but not sure how often audits were completed.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate for 1 of 4 residents (Resident #6) during the medication pass on 03/08/23 at 8:05am related to inaccurate documentation of a medication used to treat high	D 367	DRC or Designee to complete monthly MAR reviews to ensure accurate transcription and discontinuing of orders. ADRC, Wellness Nurse, or Designee to complete monthly MAR audits at the end of each month. First and Second MAR checks to be completed by ADRC and Wellness Nurse for accuracy.	4/23/23

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D 367	Continued From page 17 blood pressure, and 1 of 5 sampled residents (Resident #1) related to a medication used to treat severe vitamin D deficiency. The findings are: Review of the facility's Medication Management Policy dated 04/01/19 revealed: -All medications provided to a resident are ordered, in writing, by the resident's physician/healthcare provider. -A valid physician's order must include the date, resident name, name of medication, dose, direction for use, parameters and duration. -Medication administration is documented on the Medication Administration Record (MAR) at the time the medication is provided or taken. -All medications are appropriately dispensed and labeled as per prescription for the appropriate resident. -Changes in medication orders require a label change to reflect the current prescription. 1. Review of Resident #6's current FL2 dated 10/12/22 revealed: -Diagnoses included atrial fibrillation with rapid ventricular rate, mitral valve regurgitation, dysarthria, kidney failure, cerebrovascular accident, coronary artery disease, hypertension, shortness of breath, muscle weakness, and thrombocytopenia. -He was constantly disoriented. -There was an order for metoprolol succinate extended release (ER) 50mg, (used to treat high blood pressure) by mouth daily. Observation of the morning medication pass on 03/08/23 at 8:05am revealed: -The medication aide (MA) administered metoprolol succinate ER 50mg 1 tablet to	D 367		

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D 367	Continued From page 18 Resident #6. -There were thirteen metoprolol succinate ER 50mg tablets remaining in the bubble pack. Review of Resident #6's March 2023 MAR on 03/08/23 at 8:29am revealed: -There was an entry for metoprolol succinate ER 50mg, take 1 tablet by mouth every day for hypertension. -The metoprolol succinate ER 50mg was documented as administered at 8:00am from 02/01/23 to 02/27/23, with a documented "order changed 02/27/23". -There was a second entry for metoprolol 12.5mg take 1 tablet twice daily, scheduled for 8:00am and 8:00pm, which was documented as administered twice daily from 03/01/23 at 8:00am to 03/08/23 at 8:00am. Review of Resident #6's February 2023 MAR revealed: -There was an entry for metoprolol succinate ER 50mg, take 1 tablet by mouth every day for hypertension. -There was no documentation metoprolol succinate ER 50mg was administered, with a hand-written note, which documented this exception as "order changed 02/27/23". -There was a second entry for metoprolol 12.5mg take 1 tablet twice daily, scheduled for 8:00am and 8:00pm, which was documented as administered on 02/28/23 at 8:00pm. A subsequent observation of Resident #6's medications available for administration on 03/08/23 at 11:09am revealed: -There was a bubble pack of metoprolol succinate ER 50mg on the cart with a pharmacy label to take one tablet by mouth every day. -There were thirteen metoprolol succinate ER	D 367		

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D 367	Continued From page 19 50mg tablets remaining in the bubble pack. -There were no other bubble packs of metoprolol succinate ER 50mg for Resident #6 in the facility. Interview with the first shift MA on 03/08/23 at 11:09am and 12:01pm revealed: -She looked for an order dated 02/27/23 to change the metoprolol succinate ER 50mg to metoprolol 12.5mg twice daily. -She had only administered metoprolol succinate ER 50mg daily, even though the MAR documented metoprolol 12.5mg twice daily. -A third shift MA had transcribed the metoprolol 12.5mg twice daily accidentally on Resident #6's MAR. -The entry for metoprolol 12.5mg twice daily was meant for another resident. -The MAs had not performed a second check of the changed metoprolol 12.5mg entry on Resident #6's MARs, so it was "mixed-up" with another resident. -All of the MAs had continued to administer the metoprolol succinate ER 50mg daily, but did not notify the pharmacy or the MA supervisor. -The incorrect dose was never administered to Resident #6. A subsequent review of Resident #6's March 2023 MAR on 03/09/23 at 10:57am revealed: -There was an entry for metoprolol succinate ER 50mg, take 1 tablet by mouth every day for hypertension. -The metoprolol succinate ER 50mg entry was never documented as administered with a hand-written note which documented "order changed 2/27/23", which was marked through, and documented as "error" and "rewritten" with no date. -There was a second hand-written entry for metoprolol 12.5mg take 1 tablet twice daily, which	D 367		

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D 367	Continued From page 20 was documented as administered twice daily from 03/01/23 to 03/08/23. -There was a third hand-written entry for metoprolol succinate ER 50mg, take one tablet by mouth everyday at 8:00am, which was documented as not administered from 03/01/23 to 03/09/23. Attempted telephone interview with Resident #6's primary care provider (PCP) on 03/09/23 at 11:30am was unsuccessful. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/09/23 at 3:16pm revealed: -Metoprolol succinate ER 50mg, take one tablet daily was dispensed on 01/19/23 for a quantity of 30, and on 02/17/23 for a quantity of 30. -The original order for metoprolol succinate ER 50mg was written on 07/24/22. -They had not received an order to change metoprolol succinate ER 50mg to metoprolol 12.5mg twice daily. A third observation of Resident #6's medications available for administration on 03/09/23 at 4:12pm revealed: -There was a bubble pack of metoprolol succinate ER 50mg on the cart with a pharmacy label to take one tablet by mouth every day. -There were twelve metoprolol succinate ER 50mg tablets remaining in the bubble pack. Interview with the RCD on 03/09/23 at 11:49am revealed: -The MAs should have clarified the metoprolol 12.5mg twice daily entry on the MAR with the pharmacy prior to administering the medication. -The bubble pack for metoprolol succinate ER 50mg daily should match the entry on the MAR.	D 367		

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D 367	Continued From page 21 Interview with a second shift MA on 03/09/23 at 4:10pm revealed: -She administered metoprolol 12.5mg on 02/28/23, 03/01/23, 03/02/23, 03/05/23, 03/06/23 and 03/07/23 at 8:00pm. -She cut the metoprolol succinate ER 50mg tablet into 4 pieces and administered 12.5mg (1/4 of a tablet) to Resident #6. -She put the remaining ¾ tablet into the sharps container. -She was not sure if Resident #6's chart had been audited. A second interview with the RCD on 03/09/23 at 5:06pm revealed: -She did not recall seeing an order to change Resident #6's metoprolol succinate ER 50mg daily to metoprolol 12.5mg twice daily. -When a medication was changed, the MA should call the pharmacy to get the updated medication sent to the facility. -She was not sure if the facility's medication administration policy allowed for medications to be cut in half or quartered. -They had not kept records of the chart audits performed. -They kept a new medication order binder in the medication room on the second floor. -There were no new or changed orders in the binder for Resident #6. Refer to interview with a second shift MA on 03/09/23 at 4:10pm. Refer to interview with the RCD on 03/09/23 at 11:49am. Refer to interview with the Administrator on 03/09/23 at 10:52am.	D 367		

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D 367	Continued From page 22 2. Review of Resident #1's current FL2 dated 11/27/23 revealed: -Diagnoses included traumatic subdural hematoma, history of falls, congestive heart failure, chronic kidney disease stage III and atrial fibrillation. -He was intermittently confused. -There was an order for vitamin D (used to treat severe vitamin D deficiency) 25mcg by mouth daily. Review of Resident #1's record revealed he was hospitalized from 01/07/23 to 02/02/23. Review of Resident #1's January 2023 Medication Administration Record (MAR) revealed there was no entry for vitamin D 25mcg by mouth daily. Review of Resident #1's February 2023 MAR revealed there was no entry for vitamin D 25mcg by mouth daily. Review of Resident #1's March 2023 MAR on 03/08/23 at 4:27pm revealed there was no entry for vitamin D 25mcg by mouth daily. Observation of Resident #1's medications available for administration on 03/08/23 at 4:30pm revealed there was a bubble pack of vitamin D 25mcg with three doses missing. Interview with a second shift medication aide (MA) on 03/08/23 at 4:30pm and 4:55pm revealed: -She did not know Resident #1 had an order for vitamin D. -She had not administered vitamin D to Resident #1.	D 367		

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D 367	Continued From page 23 -She could not find any documentation where a MA had administered vitamin D to Resident #1. -The MAs, the Assistant Resident Care Director (ARCD) and the Resident Care Director (RCD) were responsible for faxing medication orders to the pharmacy, clarifying medication orders, verifying the MAR was accurate and documenting orders on the MAR. -All medication orders were placed in the residents' records. Telephone interview with Resident #1's Primary Care Provider (PCP) on 03/09/23 at 10:25am revealed he did not know the resident was not receiving the vitamin D. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/09/23 at 12:37pm revealed: -Resident #1's FL2 dated 01/27/23 was faxed to the pharmacy on 03/02/23 requesting that pharmacy fill and dispense vitamin D 25mcg. -There was no record the pharmacy had received Resident #1's FL2 prior to 03/02/23. The ARCD was unavailable for interview on 03/09/23. Interview with the RCD on 03/09/23 at 11:49am revealed: -She did not know Resident #1 had not been receiving vitamin D. -She did not know why Resident #1's vitamin D order was missed. -The MAs should have called the pharmacy for the vitamin D order prior to administering the medication and should have transcribed the vitamin D order on the MAR once the order was verified and received.	D 367		

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D 367	Continued From page 24 Interview with the Administrator on 03/09/23 at 10:52am revealed he did not know Resident #1 had not been receiving vitamin D. Refer to interview with a second shift MA on 03/09/23 at 4:10pm. Refer to interview with the RCD on 03/09/23 at 11:49am. Refer to interview with the Administrator on 03/09/23 at 10:52am. --- Interview with a second shift MA on 03/09/23 at 4:10pm revealed: -The MAs were responsible for transcribing physician orders to the MARs. -The MAs were supposed to have actual signed physician orders prior to updating the MARs. -The ARCD and the MAs were responsible for performing chart audits. Interview with the RCD on 03/09/23 at 11:49am revealed: -The MAs, the ARCD and the RCD were responsible for faxing medication orders to the pharmacy, clarifying medication orders, verifying the MAR was accurate and documenting orders on the MAR. -The ARCD was responsible for auditing the charts, medication carts, and MARs weekly. -She did not know if there was any documentation in place for these audits. -The MAs were allowed to transcribe orders to the MAR only when they had an actual physician's order. -The MAs were not to administer any medications without a physician order, or if it was not listed on the MAR.	D 367		

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LEGACY HEIGHTS SENIOR LIVING COMMUNITY	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 367	Continued From page 25 -If the medication in the bubble pack did not match the entry on the MAR or there was no signed physicians' order, the MAs should follow-up with the ARCD. Interview with the Administrator on 03/09/23 at 10:52am revealed: -The MAs, the ARCD and the RCD were able to transcribe orders on the MAR. -He thought the MAs on third shift were completing medications cart audits every week but was not certain. -The RCD and the ARCD were responsible for auditing the charts and medication orders, but not sure how often audits were completed.	D 367		