STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 survey and complaint investigation on May 27 through June 3, 2015 with an exit conference via telephone on June 3, 2015. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on May 19, 2015	D 000		
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 to meet the routine and acute health care needs of 1 of 5 sampled residents (Resident #4) regarding the need for CPAP (continuous positive airway pressure) therapy. The findings are: Review of Resident #4's current FL-2 dated 05/07/15 revealed: -Diagnoses of muscular sclerosis, sleep apnea, hypertension, and obesity. -An admission date of 05/06/15. -No orders for CPAP. Observation on 05/28/15 at 7:35 am revealed: -The Medication Aide (MA) woke Resident #4 for fingerstick blood sugar testing.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 1 -The resident was not wearing the CPAP mask. -The CPAP machine was on the night stand. Interviews on 05/28/15 at 7:37 am and 9:05 am with Resident #4 revealed: -She had not used the CPAP since admitted to the facility because she "did not have an order". -The last time she wore the CPAP was the night before she was admitted to the facility. -She brought the CPAP machine with her when she was admitted to the facility. -She had a sleep study done 3 years ago and had been on CPAP since that time. -During admissions to the hospital, hospital staff always came and checked the machine to make sure it was working properly before she began using it, so she thought the facility staff would do the same. -Last week, she asked a MA if they were going to start her CPAP and was told "not to use it" because they did not have an order for it. -She stated the MA's response gave her the impression that she needed to call the doctor herself to get an order for the CPAP, but she had not tried to call the doctor for an order. -The resident stated she knew she snored and was tired all the time, but she was tired all the time anyway because of the multiple sclerosis, so she could not really tell if not wearing the CPAP made a difference. -She would use the CPAP if the facility got an order for it. Interview on 05/29/15 at 9:30 am with the resident's family member revealed: -The resident had the CPAP machine with her when she was admitted to the facility. -He was "kind of iffy" about whether or not she used the CPAP regularly prior to admission to the facility.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 2 -She had an appointment with the neurologist just prior to admission to the facility because her blood pressure and sleeping patterns were "erratic" and she was "out of it". -Resident #4 told the neurologist she had not been using the CPAP regularly, and a review of the stored data in the machine confirmed that she had not been using the CPAP correctly for the past 6 months. -The neurologist told the resident she needed to be wearing the CPAP every night. Interview on 05/29/15 at 8:20 am with a MA revealed: -She saw the resident's CPAP machine on the night stand about the 3rd or 4th day after she was admitted. -The MA asked the resident if she used the CPAP and the resident said, "not anymore". -The MA looked on the FL-2 and did not see any information about the CPAP so she assumed the resident had stopped using it prior to admission. -The MA did not contact the physician to obtain an order regarding CPAP use. Interview on 05/29/15 at 8:34 am with a second MA revealed: -She remembered seeing the CPAP at the resident's bedside soon after the resident was admitted. -The MA asked another MA if the resident was supposed to be using the CPAP and the MA said the resident did not have an order. -The MA did not attempt to contact the physician to obtain an order regarding CPAP use. On 05/28/15, the facility provided a physician's order dated 05/28/15 to start using the CPAP machine nightly on 05/28/15.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 3	D 338		
D 338	10A NCAC 13F .0909 Resident Rights	D 338		

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observation, interview and record review, the facility failed to assure that residents were free from abuse as related to one staff member (Staff F) with an alleged sexual abuse on 05/14/15 for 1 of 1 sampled residents (Resident #3).

The findings are:

Review on 5/27/15 at 9:30 am of the Resident Roster revealed:
- There had been a total of 46 residents listed as residing in the facility.
- Thirty-three residents listed on assisted living (AL) hallways (100, 200, 300).
- Thirteen residents listed on the special care unit (SCU), 400 hall.

Review of Resident #3's record revealed:
- An admission date of 03/07/2011 and had resided on the 300 AL hall at the time of the incident.
- A physician's notation dated 04/21/15 with diagnoses for Resident #3 of unsteady gait and Alzheimer's Dementia.

Review of Resident #3's current FL2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 4 04/20/15 revealed: - Diagnoses of cardiomyopathy, urinary retention, history of DVT (deep-vein-thrombosis), cardio defibrillator & pacemaker, anemia, cellulitis, GERD, hyperlipidemia. - Documentation the resident was semi ambulatory checked with w/c (wheel chair) indicated. - Contractures were checked in the functional limitations section. - Documentation the resident was incontinent of bladder and bowel. - Documentation the resident needed personal care assistance for bathing and dressing. - Verbal was checked under the communication of needs section. Review on 05/27/15 of Resident #3's current personal care assessment signed by the physician on 02/23/15 revealed: - Documentation the resident was ambulatory with aide or device(s), wheel chair. - Documentation the resident was always disorientated. - Documentation the resident was fully dependent with bathing, dressing, transfers and toileting. Review of Resident #3's May 2015 Medication Administration Record (MAR) revealed Resident #3 had been administered the following medications for the entire month: - Coreg 3.125mg at 8:00 am and 8:00 pm (used to treat high blood pressure and congestive heart failure). - Lasix 20mg 8:00 am (used to treat edema and high blood pressure). - Coumadin 3.5mg at 4:00 pm (Coumadin 3.5mg on Monday, Tuesday, Thursday, Friday and Saturday, 4mg on Sunday and Wednesday) (a blood thinner used to prevent blood clotting).	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 5 - Zoloft 50mg at 8:00 am (used to treat depression and anxiety disorders). - Zocor 40mg at 8:00 pm (used to treat high cholesterol). Review of facility progress notes revealed a 05/14/15 care note entry, (time not entered) made by a Medication Aide (MA), "patient was bleeding from rectum and vomited brown coffee ground consistency emesis. A family member met Emergency Medical Service (EMS) at the (local hospital)." Review of facility accident/injury reports revealed a completed report signed by the second shift MA on 05/14/15, with 10:40 pm indicated as the time of the incident and 05/14/15 indicated as the date of the incident, "patient was bleeding from rectum and vomited brown, coffee ground consistency". Review on 05/27/15 of Health Care Personnel Registry 24-hour initial report revealed: - Under allegation description section an incident date of 05/14/15, time listed as 10:31 pm with "resident found in room laying on bed, found bleeding from rectal area, following vomiting. EMS called, admitted to the hospital". - Under the accused individual information section was listed "n/a, none known". - The document was signed by a Senior Executive Director on 05/17/15. Review on 05/28/15 of Resident #3's 05/15/15 Gynecological consultation record revealed: - Emergency room physician had contacted OB-GYN physician for consultation due to "no rectal bleeding but profuse vaginal bleeding". - "The injuries seen were consistent with rape and not a Gyn(ecological) related cancer as suspected."	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 6 Review of hospital records revealed Resident #3's cause of death was aspiration pneumonia on 05/17/15 at 9:50 am. Observation on 05/28/15 of recording from facility's security camera for 300 AL hall with the Senior Director of Operations and Clinical Services for the facility corporation revealed: - A total of 422 events were caught on camera from 12:30 pm on 05/14/15 to 12:20 am on 05/15/15. - The camera was motion activated. - At 4:58 pm Resident #3 was seen being pushed in her wheelchair by Staff F, Personal Care Aide (PCA), in the direction of the dining room. - At 6:02 pm Resident #3 was seen being pushed in her wheelchair by Staff F, PCA, into her room. - At 6:03 pm Resident #3 was observed moving herself in her wheelchair out into the hallway. - At 6:20 pm Staff F, PCA, entered Resident #3's room and came back out at 6:24 pm with an empty wheelchair, which he placed along one side of the hallway (staff report when wheelchairs are placed on the side of the hallway that indicated the resident had been put to bed). - At 6:52 pm, Staff F, PCA is observed coming out of Resident #3's room with a bag in his hand. - From 6:52 pm to 10:18 pm the only person/staff observed entering Resident #3's room was the Medication Aide (MA) at 7:47 pm. Staff were observed up and down the hallway. - At 10:18 pm Staff F, PCA entered Resident #3's room (staff report this is when Resident #3 was found on her bed, bleeding). Interview on 05/27/15 at 3:15 pm with a MA revealed: - She was the second shift MA on 05/14/15. - Resident #3 required assistance with transfers.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 7 - She had administered Resident #3's 8:00 pm medications on 05/14/15. - Resident #3 had been "lying in bed and was not acting different or strange". - Around 10:00 pm on 05/14/15 Staff F, personal care assistant (PCA), came to the nurse's station to report Resident #3 had been bleeding. - She had gone with the Resident Care Coordinator (RCC)/Special Care Coordinator (SCC), Supervisor and Staff F, PCA, to Resident #3's room. - The RCC/SCC had pulled back the covers off of Resident #3 and there was a "pool of blood around her bottom". - "I went and called 911." - When she returned to the room Resident #3 started vomiting. - EMS arrived and took Resident #3 to the local hospital. - Staff F, had been the one PCA assigned to work "that wing" (300 hall). - Staff F, had made comments about how he was the only staff that took care of the residents. Second interview on 05/28/15 at 1:00 pm with the second shift MA revealed: - She had only heard staff talk about Resident #3 had been a "digger". - Digging meant that she would "dig in her (feces) and spread it around". - She had never witnessed Resident #3's "digging" behavior. Telephone interview on 05/29/15 at 9:15 am with the Gynecologist who conducted Resident #3's exam revealed: - "Somebody did this to her." - Resident #3 had "very short" nails and did not have the dexterity to do this to herself.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 8 Third interview on 05/29/15 at 9:30 am with second shift MA revealed: - She had to wake-up Resident #3 to give her 8:00 pm medication on 05/14/15. - Resident #3 was "alert". She said "OK sweetie" when asked if she wanted her medications and said "thank you". - Resident #3 "wasn't pale" and "did not ask for assistance". - Resident #3 said she was "OK". Interview on 05/27/15 at 3:40 pm with the second shift Supervisor/MA revealed: - She had been working second shift on 05/14/15. - She had seen Resident #3 "at dinner around 5:00 pm" and had "no concerns, (Resident #3) was acting like herself". - At "approximately 10:30 pm, when (Staff F) had been doing last bed checks, Staff F, PCA, ran up the hallway to the nurses station to say (Resident #3's) brief was full of blood". - She, along with the RCC/SCC and MA, had gone to Resident #3's room, she had observed "blood in her brief" and Resident #3 "started vomiting" when the RCC sat her up. Second interview on 05/28/15 at 3:05 pm with the second shift Supervisor/MA revealed: - Resident #3's digging behavior happened mostly following a bowel movement (BM). - That was when she had observed Resident #3's digging behaviors. Interview on 05/27/15 at 4:00 pm with the RCC/SCC revealed: - She started employment at the facility on 04/08/15 as the RCC and was moving into the SCC position. - After 10:00 pm Staff F had come from Resident #3's room stating she was "pale and having a	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 9 hard time breathing". - She, the Supervisor, MA and Staff F went to Resident #3's room. - She observed blood "around her (Resident #3) bottom" and the pad under her had been bloody. - They sat Resident #3 up, she was "talking a little bit" then she started to vomit. - The MA was sent to call 911. - They changed Resident #3's "top and covered her because she was saying she was cold". - She went and called Resident #3's family member/ power of attorney (POA). - EMS had arrived when she returned to the room. - She had "minimal interactions" with Resident #3 during the day. - She had received no reports or concerns about Resident #3. Second interview on 05/29/15 at 10:55 am with RCC/SCC revealed: - The frequency for staff to check on residents "depends on the residents' needs, standard is every two hours". - "If the resident was oriented and could use the call bell, then every two hours." - For Resident #3, "I would expect about every half-hour to peek their head in, lay eyes on and make sure she was OK". - She stated staff are always up and down the hallways looking in on the residents. - Resident #3 used the call bell a couple of times, mostly she would "call out to staff". - On 05/14/15 she had been holding Resident #3's hand and asked her what had happened. She stated Resident #3 did not say what had happened. She was "unable to understand what (Resident #3) had been saying". - She had no knowledge of Resident #3's digging behavior and only learned of it the night of the	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 10 incident (05/14/15). Interview on 05/27/15 at 2:30 pm with a housekeeper revealed: - She had worked on 05/14/15 from 7:00 am to 7:00 pm. - She had been getting ready to "clock out" when she saw Resident #3 with "BM on her hands". - When she told Staff F "he started cursing, saying she's (Resident #3) always doing that [expletive], I'm tired of that [expletive] and she ain't going to do that [expletive] anymore". - She had observed Staff F in the "community bath giving (Resident #3) a shower, she was sitting in the shower chair". - She had "voluntarily" went to the local law enforcement on 05/25/15 because she thought what Staff F had said to Resident #3 was a threat. Interview on 05/27/15 at 3:40 pm with the second shift Supervisor/MA revealed: - The only performance counseling she had completed with Staff F had to do with "he did not like to shower the residents due to not wanting to get them wet, cold and risk getting them sick. He would use a diaper wipe instead". - She had no other concerns with Staff F's, performance or interactions with residents. Interview on 05/27/15 at 4:00 pm with the RCC/SCC revealed: - She found Staff F to be "attentive and endearing" to the residents. - He would report any resident concerns to her. - She had never heard or witnessed Staff F being aggressive or threatening to the residents. - She had no concerns of Staff F's interactions with the residents. - Staff F was supervised by the second shift	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 11 supervisor/MA. Interview on 05/27/15 at 4:45 pm with a PCA revealed: - She had been working on A-Wing (100 hall, AL) on 05/14/15. - She stated after Resident #3 left with EMS, Staff F had said he had caught (Resident #3) digging with a brush "several times". Review on 05/27/15 of Resident #3's Activities of Daily Living (ADL) log for 05/14/15 revealed from 3:00 pm to 11:59 pm Staff F had assisted Resident #3 with bathing, dressing, transfers and toileting. Telephone interview with Staff F on 05/28/15 at 3:28 pm revealed: - He had been working at the facility since October 2014. - He provided personal care services, incontinent care, dressing, grooming, position changes, feeding and showering. - On 05/14/15 "I worked a double" shift, started work at "6 something in the AM". - "After dinner, between 7:00 pm - 8:00 pm, she's in the hallway (Resident #3)." - "I saw BM on her fingers and hair" and said "oh no, not again". - He took Resident #3 to the shower, "got her toiletries, a gown, put her clothes in soiled linen". - He had put (Resident #3) on the shower chair, finished washing her, dressed her and put her in bed and elevated her head. - He made his "last round at 9:00 pm" and it was "10:15 pm to 10:30 pm by the time I got back to her (Resident #3) room, I did not see her between". - When he went in Resident #3's room she "looked pale".	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 12	D 338		

- "I pulled back the covers, all I see was blood."
- He stated the pad under Resident #3 had been "saturated, soaked".
- He "ran down the hallway, heard the (RCC/SCC and Supervisor) in the office talking and told them (Resident #3) was laying in blood".
- "They came to (Resident #3's) room, RCC/SCC trying to comfort her."
- He stated "gritty, brown stuff shot out of her (Resident #3's) mouth".
- He stated Resident #3 was "awake, talking, acting normal".

Telephone interview on 06/01/15 at 12:12 pm with the clinical organizer for Resident #3's primary care provider (PCP) revealed:
- The PCP was out of the country and unavailable.
- The PCP did not return telephone call by exit.

Review of Resident #3's records revealed:
- On 05/17/15, the local law enforcement agency informed the facility of Resident #3's death.
- On 05/17/15, the local law enforcement agency began investigating the cause of Resident #3's death and alleged sexual assault.

Interview on 05/28/15 at 2:45 pm with the local law enforcement detective assigned to the investigation revealed:
- The hospital notified the local law enforcement department of the alleged assault on 05/15/15.
- Specimens collected on 05/15/15 were at the laboratory pending results at this time, hopes to get results in the next three weeks.
- He requested the State Bureau of Investigation involvement due to their lab's quicker turn-around time with lab test results.
- He had no concerns at this time about the care or safety of the residents at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 13 - He felt the residents were safe at the facility. - The facility had been very cooperative with the investigation. Telephone interview on 05/28/15 at 1:15 pm with the investigator from the local medical examiner's office revealed: - Local law enforcement agency are the "point of contact" regarding the investigation. - The manner of (Resident #3's) death is "undetermined" at this time. - It will be a 3-4 month time frame before the autopsy is completed and findings are made public. Interview on 05/29/15 at 12:10 pm with the Senior Director of Operations and Clinical Services for the facility corporation revealed: - Staff from the medical examiner's office had come to the facility earlier today for Resident #3's medical records. - She reported the medical examiner was still determining what happened to Resident #3 and when it happened. - She reported the medical examiner was determining if Resident #3's injuries could have been self-inflicted. Telephone interview on 06/02/15 at 9:25 am with the local law enforcement detective assigned to the investigation revealed: - An arrest had been made on Friday (05/29/15). - There "may be additional charges". - He cannot release any information because this was an "on-going" investigation, they were still conducting interviews, collecting and analyzing evidence and data. - Only the local District Attorney could release any information regarding the investigation.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 14 Interview on 06/02/15 at 10:16 am with the Senior Nurse Consultant from the facility's contracted consulting company revealed: - She first heard of the allegation on Sunday, 05/17/15. - She had completed external exams on all female residents within 48 hours of the death report. - She began "wellness exams" on 05/18/15 of all the female residents in the facility. - The wellness exam consisted of an assessment of overall skin condition, any redness, swelling, marks on the body, and an observation of the vaginal area to assess for any redness, discharge, odor, swelling or anything abnormal. - She observed one resident with vaginal "warts" and one resident with a suspected urinary tract infection. - "Two or three" residents refused the exam. - She did not find any residents with bleeding, swelling or redness of the vaginal area. Observation on 06/02/15 of five female residents' physical assessments conducted by two facility registered nurses revealed: - The five female residents had diagnoses that included dementia. - Two of the five residents had suspicious findings. - Both residents with suspicious findings were sent to the local emergency room for further evaluation. Review on 06/03/15 of the emergency room evaluation dated 06/02/15 revealed both residents were evaluated by a physician with no findings suspicious for sexual assault. Interview on 06/02/15 at 9:15 am with the Senior Executive Director revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 15 - He was at the facility providing additional administrative support. - Male caregivers are scheduled to work on the 300 and 400 Halls only (300 hall is AL, 400 hall is SCU). - Residents on the 300 and 400 halls are more likely to need additional assistance with transfers. - Staff F, PCA, worked on the 300 hall only. Interview on 06/02/15 at 9:50 am with a PCA revealed: - She worked on all four halls in the building, providing care to residents. - She had not encountered any issues with residents bleeding into their incontinent briefs. - She had not observed any resident having rectal or vaginal bleeding. - She was not aware of any resident who resisted personal care. Interview on 06/02/15 at 10:05 am with a PCA revealed: - She worked mostly on the 200 (AL) hall. - She never found blood in an incontinent brief. Interview on 06/02/15 at 10:45 am with a PCA revealed: - She worked on all four halls. - She had not experienced any resident have rectal or vaginal bleeding. - She was not aware of any resident who yelled or said "no" while receiving personal care. Interview on 06/02/15 at 10:52 with a PCA revealed: - He only worked on the 300 (AL) and 400 (SCU) halls. - He had observed a scant amount of blood in the brief of a female resident who received Hospice care.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 16	D 338		

- He did not know the diagnosis of the female resident, but he had reported it to his supervisor and to the Hospice nurse.
- He had never observed a resident with active rectal or vaginal bleeding.

Interview on 06/02/15 between 1:40 pm and 2:10 pm with 3 female residents on the 100 (AL) hall revealed:
- One of the cooks was a male employee.
- The staff was very kind and helpful.
- Only females helped them with personal care and showers.

Observation on 06/02/15 between 2:25 pm and 2:32 pm of perineal exams performed by the Senior Nurse Consultant from the facility's contracted consulting company, on two non-ambulatory, disoriented female residents revealed:
- No bleeding.
- No redness.
- No discharge.
- No bruising.
- No skin tears.
- No visible abnormalities.
- The resident not resist the exam.

Interviews on 05/27/15 from 9:45 am until 10:30 am with the assisted living residents during the initial tour revealed:
- Two female residents on the 100 (AL) hall stated they did not feel safe at the facility, they had increased anxiety due to the recent incident at the facility.
- They stated they were not afraid of any specific staff, and had no concerns about any staff.
- No other residents on the 100 (AL) hall stated any safety concerns.
- No residents on the 200 (AL) and 300 (AL) halls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 17	D 338		

expressed any concerns regarding staff, safety or feeling afraid.

Review of Staff F's employee record revealed the following:
- He was hired on 11/17/14 as a PCA.
- He passed the North Carolina state Certified Nursing Assistant exam on 01/19/13.
- A Health Care Personnel Registry (HCPR) check had been completed on 10/29/14 and again on 02/24/15 (when the facility had changed ownership).
- Both HCPR checks revealed no significant findings.
- A Criminal Background check had been completed on 10/29/14 and again on 02/24/15.

Interview on 06/02/15 at 2:30 pm with Resident #3's Power of Attorney (POA) revealed:
- Resident #3 was admitted to the facility on 03/07/2011.
- He would visit Resident #3 about two times per week and another family member would visit weekly.
- The only changes he had seen with Resident #3 were a result of the normal aging process.
- He described Resident #3 as being "very talkative, joked around, a social butterfly".
- He observed improvement in Resident #3 when she was moved out of the SCU and into a room on the 300 (AL) hall (Resident #3 did not require the level of care provided on the SCU).
- He stated Resident #3 became more mobile in her wheelchair and more talkative.
- He stated prior to the incident on 05/14/15 he had no overall concerns with the facility.

Interview on 05/29/15 at 11:45 am with the Administrator revealed:
- She had not had any issues with Staff F's, PCA,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 18	D 338		

performance, "no one had reported anything to me".
- Staff F "knew the residents, what they liked and disliked".
- Staff F had been "attentive, involved and residents responded well to him".
- Staff F would frequently go up and down the hall checking on the residents.
- "I'm pleased with him (Staff F)."
- On the evening of 05/14/15 she had been discussing resident housing issues with Staff F on the 300 Hallway and Resident #3 was present in her wheelchair. Resident #3 had been "responsive, she had conversation, call it word salad".
- She had no concerns of her health or demeanor.
- She had only heard "in passing" that Resident #3 was a digger.
- She stated digging was not uncommon behavior for memory loss patients.

_____

A plan of protection was received from the facility on 06/02/15 and included the following:
- Employee assigned during the time in question was given administrative leave as of 05/18/15 with pay until such time charges were filed on 05/29/15.
- Employee in question relieved of duties on 05/29/15.
- HCPR initial report submitted on 05/17/15, 5-day report submitted on 05/22/15, HCPR addendum submitted on 05/29/15.
- Increased supervision implemented on 05/17/15 and on-going on all shifts.
- New approved locking device installed 05/19/15 on hallway door (C-Wing) which does not allow unauthorized entry to the building.
- RN supervision alternating with Senior Administrator supervision put in place on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 338	Continued From page 19 05/17/15, for day-to-day oversight of resident activities for 30 days and then one time weekly for 6-weeks and then periodically on-going. - Verified the DHSR Complaint Intake Unit number was posted and available to all residents, families and employees on 05/17/15. - Declaration of resident rights training conducted by Ombudsman on 05/15/15 and contact information posted and provided. - Declaration or resident rights review provided by facility on 05/29/15 thru 05/31/15 for all staff on duty. - Compliance will be monitored by the Executive Director, Sr. Executive Director or other designated Senior Management Personnel. THE DATE OF CORRECTION FOR THIS A1 VIOLATION SHALL NOT EXCEED JULY 3, 2015.	D 338		
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 ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 3 residents (Resident #6) observed during the morning medication pass.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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	Continued From page 20 The findings are: 1. Review of Resident #6's current FL-2 dated 04/20/15 revealed: -Diagnoses included coronary artery disease. -An order for Coreg 6.25 mg twice daily with meals at 8:00 am and 5:00 pm. (Coreg is a beta blocker.) Review of Resident #6's record revealed a physician's order dated 05/05/15 for Coreg 12.5 mg twice daily with meals. Review of the May 2015 Medication Administration Record (MAR)revealed: -Coreg 12.5 mg was scheduled for administration daily at 8:00 am and 4:00 pm. -The administration instructions on the MAR included instructions to administer with meals. Review of the Coreg pharmacy label revealed instructions to administer with meals. Observation on 05/28/15 at 7:15 am revealed the Medication Aide (MA) administered Coreg 12.5 mg prior to the breakfast meal. Interview on 05/27/15 at 11:30 am with the Dietary Supervisor revealed breakfast was served daily beginning at 8:00 am. Interview on 05/28/15 at 11:32 am with the MA revealed: -Resident #6 liked to take her medications before breakfast. -The MA did not realize she was not administering the medication according to the physician's order.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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	Continued From page 21 Based on attempted interview, it was determined Resident #6 was not interviewable. 2. Review of Resident #6's current FL-2 dated 04/20/15 revealed: -Diagnoses included chronic obstructive pulmonary disease. -An order for Advair Diskus 500/50 one puff twice daily with instructions to rinse mouth after use. (Advair is a combination steroid and bronchodilator medication.) Observation on 05/28/15 at 7:29 am revealed: -The Medication Aide (MA) administered one inhalation of Advair 40 seconds after another inhaled medication. -The MA did not ensure the resident rinsed her mouth after administration of the Advair. Interview on 05/28/15 at 11:32 am with the MA revealed: -She knew she was supposed to wait 5 minutes between different inhaled medications. -She usually gave one inhaled medication, administered medications to someone else, and then returned to administer the second inhaled medication. -She did not wait between medications this morning because she was nervous. -The resident usually rinsed her mouth after the Advair because she was usually finishing another daily medication which was dissolved in water; however, this morning, the resident refused the other medication because it was dissolved in icy water and the resident did not like cold water. Based on attempted interview, it was determined Resident #6 was not interviewable.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTE	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D914	Continued From page 22	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure that every resident be free from physical abuse as related to residents' rights after a sexual assault. The findings are: Based on observation, interview and record review, the facility failed to assure that residents were free from abuse as related to one staff member (Staff F) with alleged sexual abuse on 05/14/15 of 1 of 1 sampled residents (Resident #3). [Refer to Tag 0338, 10A NCAC 13F .0909 Residents Rights (Type A1 Violation).]	D914		