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
	HAL060136	A. BUILDING: ______ B. WING ______	R 08/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWYERS GLEN RETIREMENT LIVING CENTER	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 a follow up survey and complaint investigation on 08/28/15 and 08/31/15. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 07/23/15.	{D 000}	Responses to the cited deficiencies Does not constitute an admission or agreement by the facility of truth of the facts alleged or conclusion set forth in the statement of deficiencies or corrective action report, the Plan of Correction is prepared solely as a matter of compliance with State Laws.	
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure implementation of a physician's order for 1 of 3 sampled residents (Resident #5) related to physician orders for weekly weights. The findings are: Review of Resident #5's current FL2 dated 05/04/15 revealed: -Diagnoses included pneumonia, asthma, dysphagia, hypertension, eating disorder, and toxic encephalopathy. -An order for weekly weights. Review of a physician's order sheet signed and	D 276	Executive Director will implement procedure for Residents and Staff to notify her of concerns through use of secured comment box located outside of Executive Director office. Executive Director and Business Office Manager will monitor weekly. Activities Director will review with Residents at monthly Resident Council meetings how to voice concerns to management starting with October meeting on 10/23/15 Emergency staff meeting held to review staff responsibility as mandatory reporters of resident incidents of violation of resident rights held on 9/9/15 Staff meeting scheduled for September 30th will reviewed availability of Facility Resident Relations line.	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jessica [signature] 10/9/15
[signature] 10/20/15

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D 276	Continued From page 1 dated 04/24/15 revealed an order for weights once a week. Further review of the resident record revealed a subsequent physician's order signed and dated on 08/12/15 included "Reminder re: order request to weigh weekly". Review of the physician's visit note of 04/13/15 revealed Resident #5 weighed 180 pounds. Review of the April 2015 Medication Administration Record (MAR) revealed: -An computer-generated entry to check weight weekly with an original order date of 03/12/15. -No documentation of weekly weights. -The order had been discontinued on the MAR as of 04/16/15. -No order to discontinue weekly weights. -No additional entry to check weights weekly were on the MAR. Review of the May 2015 MAR revealed: -An entry to check weight weekly with an original order date of 03/12/15. -An entry of a weight on 05/15/15 of 179. -No other entries of weights were on the MAR. -The order had been discontinued on the MAR as of 05/16/15. -No order to discontinue weekly weights. -No additional entry to check weights weekly were on the MAR. Review of the June 2015 MAR revealed: -An entry to check weight weekly with an original order date of 03/12/15. -An entry of a weight on 06/15/15 of 160. -No other entries of weights were on the MAR. -The order had been discontinued on the MAR as of 06/16/15.	D 276		

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D 276	Continued From page 2 -No order to discontinue weekly weights. -No additional entry to check weights weekly were on the MAR. Review of the July 2015 MAR revealed: -An entry to check weight weekly with an original order date of 03/12/15. -An entry of a weight on 07/15/15 of 165. -No other entries of weights were on the MAR. Review of the August 2015 MAR revealed: -An entry to check weight weekly with an original order date of 03/12/15 that was discontinued on 08/15/15. -No order to discontinue weekly weights. -A new entry to weigh weekly with an original order date of 08/13/15. -Documentation on 08/16/15 of a weight of "0" and on 08/23/15 of a weight of "0". Interview on 08/31/15 at 1:08pm with the physician's office nurse revealed: -He did want Resident #5 to be weighed weekly to monitor his weight. -Resident #5 had an eating disorder, and was on pureed diet with nectar thickened liquids. -He did not think there was a negative outcome for Resident #5 because the facility had not done weekly weights. Interview with a Medication Aide (MA) on 08/31/15 at 3:45 pm revealed: -The Medication Aides were alerted by the electronic MAR system when a weight was to be completed for a resident. -She was not aware that Resident #5 was to have weekly weights "because the computer had not assigned the task to weigh him weekly". -The Resident Care Coordinator entered orders into the electronic MAR system when orders were	D 276		

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D 276	Continued From page 3 written by the physician. Interview on 08/31/15 at 3:55pm with the Resident Care Coordinator (RCC) revealed: -She was responsible for entering orders for weights into the electronic MAR system. -She was responsible for comparing the previous monthly MARS to the current MARs for accuracy and completeness. -She reviewed the entry for the original order for weekly weights and found she had entered the weights as routine (which was monthly) instead of weekly. -Due to this error, the Nurse Aides (NA) nor Medication Aides (MA) received an alert to weigh Resident #5 weekly. -She corrected the error in the computer MAR system at the time of the survey. -Resident #5 was unavailable to obtain a current weight because he was admitted to the hospital last night due to decreased responsiveness.	D 276	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of truth of the facts alleged or conclusion set forth in the statement of deficiencies or corrective action report, the Plan of Correction is prepared solely as a matter of compliance with State Laws.	
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues. Based on observations, interview and record reviews, the facility failed to assure residents	{D 338}	It is the policy of Lawyers Glen to assure that resident physician ordered vital signs are accurately transcribed and followed. Effective 10/15/15 after receipt of resident new vital sign orders the Resident Care Manager or Memory Care Manager will input the new order into the pharmacy tracking system; next the order will be placed into the alternate Care Manager's box for verification that transcription is completed and accurate. The verifying/reviewing manager will initial order as proof of verification and then file in resident's chart. Executive Director will review for 30 days and then periodically after.	

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{D 338}	Continued From page 4 were treated with respect, consideration and dignity. The findings are: Based on observations, interview and record reviews, the facility failed to assure residents were treated with respect, consideration, and dignity related to not immediately reporting a resident's concerns (Resident #6) to facility management. [Refer to G.S. 131D-21 (1) Resident Rights (Type B Violation)]	{D 338}		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interview and record reviews, the facility failed to assure residents were treated with respect, consideration and dignity related to not immediately reporting a resident's concerns (Resident #6) to facility management. The findings are: Review of Resident #6's FL2 revealed diagnoses included multiple sclerosis, diabetes mellitus type 2, hypertension, arthritis, and mild cognitive impairment.	D911		

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D911	Continued From page 5 Review of Resident #6's record revealed: -An admission date of 05/06/15. -Resident #6 was her own responsible party. Review of Staff Training logs revealed: -The facility provided the following training: -Resident's Rights on 05/15/15 provided by the Ombudsman and attended by 20 staff persons. -Abuse, Neglect, and Exploitation provided on 06/10/15 by the former Executive Director and attended by 33 staff persons. -Staff A and Staff F were not listed on the attendance roster for the trainings on 05/15/15 and 06/10/15. Interview with the resident on 08/31/15 at 10:40am revealed: -She had resided at the facility since May 2015. -She enjoyed having a private room. -She felt safe and staff "always check on me." -At times, she felt unsafe around other residents who "had dementia". -She had not been approached inappropriately by other residents or staff. A second interview at the request of the resident on 08/31/15 at 2:00pm revealed: -The facility recently had renovations, which included the installation of new floors. -The facility had an outside company that replaced the floors. -The resident was concerned about an incident that happened with "one of the workers" who was installing the flooring. -She could not recall the exact date, but "it was several weeks ago." -There were two workers and they were going to replace the flooring in the shared bathroom located to the right of Resident #6's room.	D911		

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D911	Continued From page 6 -Resident #6 asked one of the workers if she needed to leave her room and the worker told her no. -She shut her bedroom door and was sitting in the recliner in her room. -One of the workers opened her door and stood in the doorway "for three or four minutes" and kept rolling his tongue around (inside and out) of his mouth and "raising his eyebrows" and looking at me. -She was very uncomfortable and thought this could have been a sexual gesture towards her. -The floor company employee did not say anything to her, nor did he make any gestures. -The employee then closed the door, said something "in Spanish" to his co-worker and she heard them laugh. -Whenever she saw the worker in the building that day, "he would grin at me." -She did not immediately report the incident to staff. -The incident happened between lunch and supper, but she did not know what time. -Staff A, Dietary Aide, was delivering afternoon snacks to her room later the same day, she thought about 2:00pm. -"I told her what happened and asked her what she would have thought if someone did that to her." -She believed Staff A reported the incident to the Executive Director the same day. -The Executive Director came to her room, she thought the same day of the incident, to talk with her. -She told the Executive Director about the incident with the employee of the flooring company who was working on the floors near her bedroom. -"The Executive Director had a meeting with all of the employees and called the supervisor of the	D911		

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D911	Continued From page 7 floor company." -"The Executive Director told me the floor company now has to have a supervisor here whenever their workers are in the building." -She had not seen the employee from the flooring company in the building again. -Resident #6 felt that facility had responded to her appropriately. A third interview with Resident #6 on 08/31/15 at 5:00pm revealed: -She was not scared enough at the time of the incident to pull her call bell to request staff assistance. -When Staff A came to her room to deliver snacks on the day of the incident, she said "I am so glad you are here. I need to tell you what happened today." -She believed Staff A informed the Executive Director of the incident on the day she reported her concerns to Staff A. -She was pleased with the response from the Executive Director. -"For several nights, I slept with those scissors under my pillow in case he came back." -"I had plans for him if he came back." -She had not told anyone that she had slept with scissors under her pillow. Observation on 08/31/15 at 4:35pm of a pair of scissors on Resident #6's dresser. Interviews with 19 residents during the survey revealed no other residents had concerns regarding inappropriate behaviors towards the residents from staff or employees of the flooring company. Interview on 08/28/15 at 3:00pm with Staff A, Dietary Aide revealed:	D911		

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D911	Continued From page 8 -She was employed as a dietary aide. -Resident #6 reported to her about 9:00pm on the same day of the reported incident that a man who was employed with the flooring company had made inappropriate gestures (rolling his tongue in and out of his mouth at the resident). -She could not recall which day it occurred, but she thought it was either 07/23/15 or 07/24/15. -The resident told her it made her feel uncomfortable. -Staff A did not report the resident's concerns to her supervisor, the Medication Aide, or the Executive Director because "the resident did not make a huge deal about it, so I didn't." -She did not know if other incidents had occurred with other residents. -She could not recall the date of the incident. Interview with Staff F on 08/31/15 at 2:40pm revealed: -He had worked at the facility for five years and was a dishwasher. -He no longer was employed by the facility. -Staff A reported to him that one of the workers of the flooring company had "said something joking, but out of line to the resident and was sticking out his tongue at her." -"It was nothing too serious." -Staff A informed him on Friday 07/24/15 of the concerns told to Staff A by Resident #6. -He was not sure of the exact day of the reported incident. -He reported the concerns to the Executive Director on 07/25/15. Interview with two Nurse Aides (NA) on 08/31/15 at 11:45am and 12:25am revealed: -They were not aware of any residents who had concerns about inappropriate behaviors towards residents from the workers of the flooring	D911		

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D911	Continued From page 9 company. -If a resident told them something concerning how they were treated, they would report it immediately to management. -One NA said the facility had Resident Rights training when they were hired. -One NA said the facility had provided Resident Rights training for staff recently. Interview with the Memory Care Coordinator on 08/31/15 at 11:30am revealed: -The staff received training from the Ombudsman "within the last two or three months" on Resident Rights. -She was not aware of any residents having concerns about inappropriate behaviors from the workers of the flooring company. -If a staff person had concerns or a resident told them of a concern about how they were treated, the staff person was to report it to the person in charge (either the Medication Aide, the Memory Care Coordinator, or the Executive Director). Interview with the Housekeeping Supervisor on 07/31/15 at revealed: -Staff had received training regarding Resident's Rights and Abuse and Neglect several times in the past few months. -The Ombudsman provided some of the training. -Her expection, as a supervisor, was that all employees were to immediately report concerns related to residents to the Medication Aide, their supervisor, or the Executive Director. Interview with the Executive Director on 08/28/15 at 4:00 pm revealed: -She was told by Staff F, a dishwasher, on 07/25/15 that "someone told me that one of the guys did something to" Resident #6. -She did not know who told Staff F about the	D911		

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D911	Continued From page 10 reported incident with Resident #6 or when he was told. -The Executive Director interviewed Staff F on 07/28/15 regarding the reported incident. -She was not aware of the reported incident involving Resident #6 and a contracted floor worker until reported to her by Staff F on 07/26/15. -Staff F no longer worked at the facility. -The Executive Director interviewed Resident #6 on 07/25/15 who told her "On Friday a worker knocked on my door and said he was going to work in my bathroom. I asked him if he needed me to leave my room and he said no. He was in the bathroom for a while and then started to look at the door way of my room. He stuck his tongue out at me a few times. It was very strange." -The resident said he "rolled his eyes and wiggled his tongue at her". -The Executive Director asked the resident if she thought the worker's actions were sexual in any way and the resident said "I don't know". -The resident did not want to contact the police at that time. -The resident was not sure if the worker was trying "to hit on me." -The resident stated it was strange, but "I could have misunderstood". -The Executive Director interviewed "a good amount" of residents on 07/25/15 after she talked with Staff F to see if any of them had concerns of inappropriate behaviors towards them by workers of the flooring company. -None of the residents she interviewed expressed concerns other than Resident #6. -The flooring company was replacing the flooring for the entire building. -The Executive Director contacted the Supervisor of the flooring company by phone on 07/25/15 to report the alleged incident.	D911		

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D911	Continued From page 11 -The Supervisor with the flooring company met with the Executive Director each morning the floor crew is in the building since the incident was reported to the Executive Director. -The floor company had increased supervision at the facility. -The Executive Director discussed in daily "stand-up meetings" the facility's reporting structure, especially who staff were to report concerns to during weekend hours. -She reviewed at a full staff meeting on 07/31/15 information about when and how staff are to report residents' concerns, how to follow the chain of command when reporting, and examples of concerns that were to be reported. -Her expection and the facility's policy was if a resident informed staff of any issues or concerns, the staff person should report it to the supervisor on duty or the Executive Director immediately. Review of the attendance sign-in sheet for the full staff meeting, which included how and when to report resident's concerns, on 07/31/15 revealed: -Forty employees attended the staff meeting. -Staff A attended the meeting as evidenced by her signature. -Staff F was listed on the pre-typed roster of facility employees, but there was no signature beside his name to indicate he had attended. A second interview with the Executive Director on 08/31/15 at 5:15pm revealed: -She was not aware Resident #6 had slept with scissors under her pillow due to concerns the floor worker would return. -She would investigate and discuss with Resident #6 immediately. -She had conducted a full-staff meeting on 08/31/15 and had reviewed Resident's Rights and reporting residents' concerns immediately.	D911		

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D911	Continued From page 12 A Plan of Protection was requested and submitted by the facility on 09/08/15 that included: -Staff meeting held on July 31, 2015 and reviewed Resident Rights incidents. -Daily stand-up meetings held twice daily for staff to voice Resident concerns. -Daily verifications of posting for Division of Health Service Regulation complaint line and Facility Resident Relations line. -Executive Director will review with residents at September Resident Council meeting how to voice any concerns to management. -Executive Director will implement procedure for residents and staff to notify her of concerns through use of a secured comment box located outside of the Executive Director's office. -Emergency staff meeting to be held with all staff within 48 hours to discuss their role as mandatory reporters of resident incidents or violation of Resident Rights. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 15, 2015.	D911		

AH Form Approved
9/14/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
HAL060136	A. Building B. Wing	8/31/2015

Name of Facility	Street Address, City, State, Zip Code
LAWYERS GLEN RETIREMENT LIVING CENTER	10830 LAWYERS ROAD CHARLOTTE, NC 28227

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix D0273 Reg. # 10A NCAC 13F .0902(b) LSC	Correction Completed 08/31/2015	ID Prefix D0358 Reg. # 10A NCAC 13F .1004(a) LSC	Correction Completed 08/31/2015	ID Prefix D914 Reg. # G.S. 131D-21(4) LSC	Correction Completed 08/31/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/3/2015			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO