STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034102	A. BUILDING: _____ B. WING _____	09/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE OF CLEMMONS	4430 CLINARD ROAD WINSTON SALEM, NC 27102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on September 13 - 14, 2017 with an exit conference via telephone on September 15, 2017.	D 000		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: Based on interviews, record review, and review of the staffing schedule, it was determined the facility failed to have at least one staff person on premises at all times who had completed a course on Cardio-Pulmonary Resuscitation (CPR) for one of fourteen days on 1st shift during the period of September 1, 2017 through September 14, 2017 for 4 of 6 sampled staff (Staff A, C, D, and E). The findings are:	D 167		

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D 167	Continued From page 1 A. Review of the personnel files for Staff A revealed: -Staff A had been employed at the facility since 6/25/16 as a Personal Care Aide (PCA). -Staff A usually worked on 1st shift. -Staff A had no documentation of completing a course in CPR. Staff A was not available for interview on 9/14/17. Refer to interview with the Administrator on 9/14/17 at 3:45pm. Refer to interview with the Resident Care Director (RCD) on 9/14/17 at 4:20pm. Refer to second interview with the Administrator on 9/14/17 at 6:40pm. B. Review of the personnel files for Staff C revealed: -Staff C had been employed at the facility since July 2016 as a PCA. -Staff C usually worked on 2nd shift. -Staff C had no documentation of completing a course in CPR. Staff C was not available for interview on 9/14/17. Refer to interview with the Administrator on 9/14/17 at 3:45pm. Refer to interview with the Resident Care Director (RCD) on 9/14/17 at 4:20pm. Refer to second interview with the Administrator on 9/14/17 at 6:40pm. C. Review of the personnel files for Staff D revealed:	D 167		

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D 167	Continued From page 2 -Staff D had been employed at the facility since 5/1/17 as a Medication Aide (MA). -Staff D usually worked on 2nd shift. -Staff D had no documentation of completing a course in CPR. Interview with Staff D at on 9/14/17 at 4:15pm revealed: -She had CPR certification and "thought that it expires in 2020." -Her CPR card was at home. -She usually worked on 2nd shift. Refer to interview with the Administrator on 9/14/17 at 3:45pm. Refer to interview with the Resident Care Director (RCD) on 9/14/17 at 4:20pm. Refer to second interview with the Administrator on 9/14/17 at 6:40pm. D. Review of the personnel files for Staff E revealed: -Staff E had been employed at the facility since 6/8/17 as a MA. -Staff E usually worked on 1st shift. -Staff E had had no documentation of completing a course in CPR. Interview with Staff E on 9/14/17 at 3:00pm revealed: -"My CPR expired." -She was scheduled to take a CPR class this month. -She usually worked on 1st shift. Refer to interview with the Administrator on 9/14/17 at 3:45pm.	D 167		

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D 167	Continued From page 3 Refer to interview with the Resident Care Director (RCD) on 9/14/17 at 4:20pm. Refer to second interview with the Administrator on 9/14/17 at 6:40pm. _____ Interview with the Administrator on 9/14/17 at 3:45pm revealed: -She had been employed as the Administrator since May 2017. -She was responsible for completing the weekly schedule. -She was aware there needed to be at least one person on every shift who was CPR certified. -She was responsible for ensuring at least one person on every shift was CPR certified. -She had been working on a document to remind her when staff CPR certification was getting ready to expire. -There had been no resident who needed CPR during the times when she was there. Interview with the Resident Care Director (RCD) on 9/14/17 at 4:20pm revealed: -She had been employed at the facility for one month. -The Administrator was responsible for completing the weekly schedule. -The Administrator was responsible for ensuring that at least one person on every shift was CPR certified. -There had been no resident who needed CPR during the time that she had worked at the facility. Second interview with the Administrator on 9/14/17 at 6:40pm revealed: -A CPR class was scheduled for Saturday, 9/16/17 at 1 pm. -Up to 8 people were scheduled for the CPR class.	D 167		

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D 167	Continued From page 4 -She had completed a staff schedule up until 9/19/17 with a CPR certified staff member covering each shift. Review of the staffing schedule for September 1, 2017 through September 14, 2017 revealed there was 1 of 14 days from 7 am to 3 pm when there was no CPR certified staff person on the premises.	D 167		
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 assure physician notification of oxygen saturation (O2 sat) levels below 92% for 1 of 3 sampled residents, (Resident #1). The findings are: Review of Resident #1's FL2 dated 9/13/17 revealed: -Resident #1 had diagnoses of vascular dementia, macular degeneration, hyperlipidemia, bone cartilage disease, and anxiety. -There was an order to check O2 sat every morning and at bedtime. -Physician was to be notified if O2 sat was under 92%. -There was an order for 2 liters of oxygen to be	D 273		

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applied at bedtime and taken off in the morning.

Review of Resident #1's record revealed:
-A signed physician's order dated 7/16/17 for staff to check O2 sat every morning and at bedtime.
-The physician was to be notified if O2 sat was under 92%.

Review of Resident #1's Medication Administration Record (MAR) for July 2017 revealed:
-There was an entry for the O2 sat to be checked at 8am and at 8pm from 7/1/17 through 7/31/17.
-The O2 sats ranged from 90% to 98% from 7/1/17 through 7/31/17
-The O2 sat was documented as 90% at 8 pm on 7/30/17.
-There was no documentation the physician was notified of O2 sats below 92%.
-There was documentation from that 2 liters of oxygen was applied at 8 pm and taken off at 8 am form 7/1/17 through 7/31/17.

Review of Resident #1's MAR for August 2017 revealed:
-There was an entry for O2 sat to be checked at 8am and at 8pm from 8/1/17 through 8/31/17.
-The O2 sats ranged from 82% to 98% from 8/1/17 through 8/31/17.
-The O2 sat was documented as 90% at 8pm on 8/12/17.
-The O2 sat was documented as 90% at 8pm on 8/16/17.
-The O2 sat was documented as 90% at 8pm on 8/17/17.
-The O2 sat was documented as 90% at 8pm on 8/30/17.
-The O2 sat was documented as 82% at 8am on 8/31/17.
-There was no documentation the physician was

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notified of O2 sats below 92%.
-There was documentation from that 2 liters of oxygen was applied at 8 pm and taken off at 8 am form 8/1/17 through 8/31/17.

Review of Resident #1's MAR for September 2017 revealed:
-There was an entry for O2 sat to be checked at 8am and at 8pm from 9/1/17 through 9/13/17.
-O2 sats ranged from 70% to 98% from 9/1/17 through 9/13/17.
-O2 sat was documented as 80% at 8pm on 9/03/17.
-O2 sat was documented as 87% at 8am on 9/04/17.
-O2 sat was documented as 90% at 8pm on 9/05/17.
-O2 sat was documented as 72% at 8pm on 9/06/17.
-O2 sat was documented as 70% at 8pm on 9/07/17.
-O2 sat was documented as 70% at 8pm on 9/08/17.
-O2 sat was documented as 70% at 8pm on 9/12/17.
-There was no documentation the physician was notified of O2 sats below 92%
-There was documentation from that 2 liters of oxygen was applied at 8 pm and taken off at 8 am form 9/1/17 through 9/13/17.

Review of Resident #1's Resident Care Notes revealed:
-There was no documentation Resident #1's O2 sat was below 92% in July 2017, August 2017, or September 2017.
-There was no documentation the physician had been contacted in July 2017, August 2017, or September 2017.

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D 273	Continued From page 7 Interview with a 2nd shift MA on 9/14/17 at 3:55pm revealed: -She had been employed at the facility for less than a month. -The MA was responsible for checking Resident #1's O2 sat 2 times a day. -The MA stated, "The doctor would be contacted if the O2 sat was under 90%." -She had documented O2 sat that was under 92%. -She had never contacted the physician nor documented in the Resident Care Notes because "she didn't know she had to." -She had not notified anyone that Resident #1's O2 sat was low. -"I just put her oxygen on when her O2 sat was under 90. I'm new and I didn't know the protocol." -She would let the 3rd shift MA know that Resident #1's O2 sat was low. Interview with a 1st shift Medication Aide (MA) on 9/14/17 at 10:25am revealed: -She had been employed at the facility for over a year. -The MA was responsible for checking Resident #1's O2 sat level. -The physician was to be contacted if O2 sat fell below 92%. -The MA was responsible for contacting the physician and documenting in the Resident Care Notes. -Resident #1's O2 sat had never fallen below 92% during her shift. -She had never contacted Resident #1's physician due to her O2 sat being below 92%. -She had never documented in the Resident Care Notes that Resident #1's O2 sat was below 92%. Interview with the Resident Care Director (RCD) on 9/14/17 at 11:17am revealed:	D 273		

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-She had been employed at the facility for one month.
-She expected
the MA to check Resident #1's O2 sat twice daily as ordered by the physician.
-The MA was responsible for checking Resident #1's O2 sat twice daily, notifying the physician, and documenting in the Resident Care Notes.
-She expected to be made aware of an O2 sat was below 92% and the physician had been notified.
-She was not aware Resident #1's O2 sat was documented in the MAR as below 92%.
-She was not aware the physician had not been notified and there was no documentation in the Resident Care Notes.
-She was in the process of retraining staff so they knew what they were supposed to do.

Interview with the Administrator on 9/14/17 at 11:30am revealed:
-She had been employed at the facility for four months.
-The MA was responsible for checking Resident #1's O2 sat twice daily.
-The MA was responsible for notifying the physician if Resident #1's O2 sat was below 92%.
-The MA was responsible for documenting in the Resident Care Notes that Resident #1's O2 sat was below 92% and that the physician was notified.
-She was not aware that Resident #1's O2 sat was documented in the MAR as below 92%.
-She was not aware that the physician had not been notified and that there was no documentation in the Resident Care Notes.

Interview with the facility Physician Assistant (PA) on 9/14/17 at 11:53am revealed:
-Resident #1 used to have a history of her O2 sat

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dropping.
-The order for O2 sat checks twice daily was in place to ensure that Resident #1's O2 sat did not drop and she was not "bottoming out."
-When Resident #1's O2 sat was below 92%, the protocol was for the facility to contact the physician's office morning or evening, and a note would be placed in the book for the PA to follow up on Wednesday when she visited.
-She had not been made aware that Resident #1's O2 sat was below 92% during the last three months.
-"The facility may have called in to triage, but I have not received any messages."
-She looked at Resident #1 on 9/14/17 and there were no issues or concerns.
-She did not perceive any negative outcomes from Resident #1's O2 sat being below 92% due to resident being on comfort care and having a Medical Orders for Scope of Treatment form (MOST form) in place.
-The goal for Resident #1 was to stay comfortable.

Interview with a 2nd shift MA supervisor on 9/14/17 at 3:30pm revealed:
-She has been employed at the facility for a year.
-The MA was responsible for checking Resident #1's O2 sat twice daily.
-"O2 sat should have been in the 90's."
-"A low O2 sat would have been in the 70's."
-Resident #1 has never had a low O2 sat level during her shift.
-She has never had to contact the physician or document in the Resident Care Notes that Resident #1's O2 sat was low.
-She has never read in the Resident Care Notes that Resident #1's O2 sat had been low.

Review of the facility's policy on Staff Monitoring

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D 273	Continued From page 10 of Resident O2 Sats revealed: -The MA monitored resident's O2 sats based on physician orders. -The signed physician order included parameters for any needed actions as well as physician reporting. -It was the responsibility of the MA taking the O2 sat to report to the physician as ordered, take any further action indicated in the order and document all action taken along with results if they were outside of desired parameters. Based on observation, record reviews, and interviews, it was determined that Resident #1 was not interviewable. Interview with Resident #1's family member on 9/15/17 at 9:15am revealed: -He was not aware of the physician's order to check O2 twice daily. -He had never been informed that Resident #1 had O2 sats below 92%. -He had never been informed the physician had been contacted because O2 sats were below 92%. -He visits Resident #1 about twice a week. -He has never noticed Resident #1 having any breathing difficulties. -He had no concerns with Resident #1's breathing.	D 273		