STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036013	A. BUILDING: _____ B. WING _____	R 10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NEW HOPE	1680 SOUTH NEW HOPE ROAD GASTONIA, NC 28054

(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 and follow-up survey on 10/09/18-10/11/18.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: This area is still out of compliance. Based on observations and interviews, the facility failed to assure walls and floors in 5 resident rooms (#7, #13, #25, #37 and #40) and in the main corridors were clean and in good repair. The findings are: Observations of the floors in resident rooms #7 and #25 and in the main corridors on 10/10/18 between 3:00pm and 3:30pm revealed: -The areas were carpeted. -The carpet in resident rooms #7 and #25 had mutiple brown stains. -In the front main corridor, there was a large brown stain approximately 12 in. by 18 in. in the carpet covering the area around the water cooler and another large brown stain approximately 24 in. by 30 in. covering the area in front of the	D 074		

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D 074	Continued From page 1	D 074		

laundry room.
-In the front main corridor, at the kitchen door, the carpet was stained brown and was dirty with food crumbs.
-In the back main corridor, there were multiple brown stains of various sizes in the carpet.

Observations of the walls in resident rooms #13, #37 and #40 and in the front main corridor on 10/10/18 between 3:00pm and 3:30pm revealed:
-In the front main corridor, the door to the laundry room contained dents, black scuff marks and peeling paint.
-In resident room #13, the right bottom third of the bathroom door frame had multiple scrapes in the wood.
-In resident room #13, the right wall inside the bathroom had an area approximately 2 in. by 6 in. where the paint was missing.
-In resident room #37, both the lower third of the bathroom door frame and the closet door frame had scratches that revealed bare wood, and the bottom of the doors had black scuff marks.
-In resident room #37, the baseboard to the left of the closet door had scratches that revealed bare wood.
-In resident room #40, there was a black scuff mark on the left wall approximately 36 in. by 2 in. in size and a black scuff mark on the right wall approximately 24 in. by 2 in. in size.
-In resident room #40, the lower third of the bathroom door frame had deep scratches that revealed bare wood, and the bottom of the door had black scuff marks.
-In resident room #40, the baseboards to the left of the bathroom door and across from the bathroom door were scratched with bare wood showing.

Interviews with four residents on 10/09/18 and

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10/10/18 at various intervals revealed:
-They had noticed the stains in the carpet.
-They would like to have new carpet.
-"The carpets were dirty and needed to be cleaned."
-The resident had heard visitors comment on the condition of the carpet. "It was embarrassing."
-The floors were vacuumed about one time per week, but she could not remember the last time they were cleaned.
-The resident had moved in a few months ago and the walls and baseboards in her room had scratches when she moved in. "It looks horrible."

Interview with the housekeeper on 10/11/18 at 12:18pm revealed:
-She vacuumed each room and each main corridor once weekly.
-The Maintenance Director was responsible for shampooing the carpets and repairing walls.
-She notified the Maintenance Director whenever she found carpets that were stained or walls that needed to be repaired.

Interview with the Maintenance Director on 10/10/18 at 3:00pm revealed:
-Wall patching and painting was completed for room #13 on 02/12/18, and for room #37 on 01/23/18.
-The carpet in room #7 was last cleaned by a professional cleaning company on 04/20/18.
-He had repaired and painted the walls and doors in room #40 on 02/18/18.
-Every 3 months, the commercial carpet cleaning company cleaned all the carpets in the common areas throughout the facility.
-He had a small carpet shampoo machine and cleaned the carpets when needed.
-He kept a log book in the staff office where any staff could document a maintenance issue.

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D 074	Continued From page 3 -Every morning he checked the log book and prioritized the repairs to be made. -Frequently he would repair damage to a wall or door from a wheelchair and the next day he would find the same area damaged again. Interview with the Administrator on 10/11/18 at 2:40pm revealed: -The facility had a contract with a professional carpet cleaning company who came in monthly and shampooed "a few rooms and corridors" each time. -They were limited by "corporate" on how many areas could be shampooed each time and she was unsure of the exact number. -The Maintenance Director was responsible for inspecting the carpet to determine which areas needed to be professionally shampooed. -The facility had a small carpet shampoo machine the Maintenance Director could use between professional cleanings, but it did not work well to remove the stains. -The professional carpet cleaning company was able to remove stains temporarily, but most stains would reappear after a few days. -Carpets were replaced in resident rooms whenever a resident moved out. -The facility did not have any future plans for replacing the carpet in the main corridors because they were one of the more recently renovated facilities in the company. -The Maintenance Director was responsible for inspecting walls and doors for needed repairs. -Staff could also notify the Maintenance Director of areas needing repaired by documenting it in the maintenance log. -The Maintenance Director worked forty or more hours each week and was responsible for all routine repairs and the complete "unit turnovers" that occurred when residents moved out.	D 074		

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D 074	Continued From page 4 -It was difficult for the Maintenance Director to keep up with repairs because he was the only person who worked in the maintenance department.	D 074		
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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to notify the physician for 1 of 5 sampled residents (Resident #5) related to blood pressure readings outside parameters. The findings are: Review of Resident #5's current FL2 dated 08/02/18 revealed diagnoses included generalized muscle weakness, dysphagia, hypertension, and chronic obstructive pulmonary disease. Review of Resident #5's physician orders dated 03/20/18 and 08/21/18 revealed to check blood pressure daily before placing nitroglycerin patch (used to treat low blood pressure and treat chest pain), if systolic blood pressure (SBP) was greater than 200 or diastolic blood pressure (DBP) was greater than 110 call doctor and if SBP was less than 90 or DBP was less than 60	D 273		

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D 273	Continued From page 5 call doctor. Review of Resident #5's August 2018 electronic Medication Administration Record (eMAR) revealed: -A computer generated entry to check blood pressure (BP) daily before placing nitroglycerin patch, call doctor with blood pressure greater than 200/110 or less than 90/60 and scheduled to be obtained at 6:00am. -A computer generated entry for nitroglycerin apply 1 patch every morning and remove at bedtime, hold if SBP is less than 120 and call physician if SBP is greater than 110 or DBP is greater than 90 scheduled to be administered at 6:00am. -Blood pressure monitoring entry had a start date of 06/27/18. -Blood pressure readings were recorded daily from 08/09/18 to 08/18/18 and 08/22/18 to 08/31/18. -Resident #5 was out of the facility in a rehab from 08/01/18 to 08/08/18 and in the hospital from 08/19/18 to 08/21/18. -The SBP ranged from 84-200 and the DBP 49-97. -Blood pressure was recorded outside of the parameters for 3 out of 20 opportunities. -Blood pressure was recorded as 84/62 on 08/10/18, 125/52 on 08/16/18, and 183/49 on 08/18/18. -Blood pressure was recorded outside of the parameters to administer the nitroglycerin patch for 3 out of 20 opportunities. -Nitroglycerin was not documented as administered on 08/10/18 (BP 84/62), 08/14/18 (BP 108/62) and on 08/15/18 (BP 102/76). Review of Resident #5's September 2018 eMAR revealed:	D 273		

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D 273	Continued From page 6 -A computer generated entry to check blood pressure daily before placing nitroglycerin patch, call doctor with blood pressure greater than 200/110 or less than 90/60 and scheduled to be obtained at 6:00am. -A computer generated entry for nitroglycerin apply 1 patch every morning and remove at bedtime, hold if SBP is less than 120 and call physician if SBP is greater than 110 or DBP is greater than 90 scheduled to be administered at 6:00am. -Blood pressure readings were recorded daily from 09/01/18 to 09/30/18 except 09/26/18. -The SBP ranged from 102-208 and the DBP ranged from 43-118. -Blood pressure was recorded outside of the parameters for 5 out of 29 opportunities. -Blood pressure was recorded as 198/110 on 09/01/18, 208/118 on 09/10/18, 171/59 on 09/20/18, 138/43 on 09/22/18, and 161/56 on 09/24/18. -Blood pressure was recorded outside of the parameters to administer the nitroglycerin patch for 6 out of 29 opportunities. -Nitroglycerin was not documented as administered on 09/02/18 (BP 108/60), 09/03/18 (BP 102/70), 09/05/18 (BP 111/83), 09/07/18 (BP 118/65), 09/08/18 (BP 98/71) and 09/15/18 (BP 117/72). Review of Resident #5's October 2018 eMAR revealed: -A computer generated entry to check blood pressure daily before placing nitroglycerin patch, call doctor with blood pressure greater than 200/110 or less than 90/60 and scheduled to be obtained at 6:00am. -A computer generated entry for nitroglycerin apply 1 patch every morning and remove at bedtime, hold if SBP is less than 120 and call	D 273		

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physician if SBP is greater than 110 or DBP is greater than 90 scheduled to be administered at 6:00am.
-Blood pressure readings were recorded daily from 10/01/18 to 10/09/18.
-The SBP ranged from 103-180 and DBP ranged from 55-87.
-Blood pressure was recorded outside of the parameters for 1 out of 9 opportunities.
-Blood pressure was recorded as 103/55 on 10/05/18.
-Blood pressure was recorded outside of the parameters to administer the nitroglycerin patch for 1 out of 9 opportunities.
-Nitroglycerin was not documented as administered on 10/05/18 with a documented blood pressure of 103/55.

Interview with the Medication Aide (MA) on 10/10/18 at 10:20am revealed:
-She did not know Resident #5 had blood pressure parameters related to receiving his nitroglycerin patch.
-The MA who obtained the blood pressure and recorded the reading on the eMAR was responsible for notifying the physician if Resident #5's blood pressure was outside the parameters set by the physician.
-The third shift MA was responsible for checking Resident #5's blood pressure before applying the nitroglycerin patch.
-She was responsible for following up with the physician if the facility did not receive a response.
-If the third shift MA had to fax the doctor regarding a resident it would go on the shift report.
-The shift report covered 24 hours and was used by the MA during each shift then given to the Health and Wellness Director (HWD) or the Resident Care Coordinator (RCC) for review.

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D 273	Continued From page 8 Interview with the RCC on 10/11/18 at 12:16pm revealed: -She knew that Resident #5 had a physician's order to contact the physician regarding elevated or low blood pressure readings. -The MA's were responsible for contacting Resident #5's physician if blood pressure reading was outside of the ordered parameters. -The HWD or RCC would audit the eMAR's and residents' records every 3 months or sooner if the resident had a significant change. Interview with the Administrator on 10/11/18 at 11:52am revealed: -The facility staff should be following all physician orders for all residents. -The MA was responsible for notifying a resident's physician if needed. -The MA was expected to notify the HWD or RCC if a resident's physician had to be notified for any reason. -The MA was responsible for recording the information on the 24 hour report and following up on faxes to the physician. -The MA should call the "house doctor" if a resident's Primary Care Physician (PCP) does not get back in touch regarding a notification. -The HWD and RCC should be auditing the vital signs recorded on eMARs regularly. Review of Resident #5's record revealed: -Resident #5 was sent to the hospital on 08/18/18 with an admitting diagnosis of urinary tract infection, pneuomonia, hyperkalemia and dehydration. -He was readmitted to the facility on 08/21/18. Telephone interview with the Certified Medical Assistant (CMA) at Resident #5's PCP office on	D 273		

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D 273	Continued From page 9 10/11/18 at 10:29am revealed: -Resident #5's last office visit was 08/31/18. -Resident #5's PCP had not been notified about any information regarding blood pressure readings. -The facility should have contacted the PCP about the low blood pressure readings in August. -The PCP could have adjusted medication dosages, asked the resident to come in for an office visit or sent the resident to the hospital. -Resident #5's hospital stay in August could have been prevented or shortened if the PCP had known that the resident was having readings outside the parameters. -Resident #5's blood pressure was at risk for dropping to dangerous levels since the facility did not notify the PCP and continued administering his blood pressure medications. Based on observations and record reviews it was determined that Resident #5 was not interviewable. The facility failed to notify Resident #5's physician regarding blood pressure readings outside of the parameters which put the resident at risk for low blood pressure and caused the resident to be hospitalized for three days. The failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/11/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 25, 2018.	D 273		

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D 276	Continued From page 10	D 276		
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 interviews and record reviews, the facility failed to implement physicians' orders for 1 of 5 sampled residents (Resident #5) related to monitoring blood pressure and pulse prior to medication administration. The findings are: Review of Resident #5's current FL2 dated 08/02/18 revealed diagnoses included generalized muscle weakness, dysphagia, hypertension, and chronic obstructive pulmonary disease. Review of Resident #5's hospital discharge summary dated 08/21/18 revealed a physician's order for metoprolol tartrate 25mg take 2 tablets twice daily, hold if systolic blood pressure (SBP) is less than 90 or pulse is less than 60. Review of Resident #5's August 2018 electronic Medication Administration Record (eMAR) revealed:	D 276		

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D 276	Continued From page 11 -A computer generated entry for metoprolol 25mg take 2 tablets two times daily for hypertension and scheduled to be administered at 8:00am and 8:00pm. -Metoprolol was documented as administered from 08/22/18 to 08/31/18. -There were no instructions on the eMAR to obtain blood pressure and pulse prior to the administration of metoprolol. -There was no documentation on the eMAR that Resident #5's blood pressure and pulse was checked prior to administration of metoprolol. -Blood pressure readings were recorded daily from 08/09/18 to 08/18/18 and 08/22/18 to 08/31/18 at 6:00am. -The SBP ranged from 84-200 and the DBP 49-97. Review of Resident #5's September 2018 eMAR revealed: -A computer generated entry for metoprolol 25mg take 2 tablets two times daily for hypertension and scheduled to be administered at 8:00am and 8:00pm. -Metoprolol was documented as administered from 09/01/18 to 09/30/18. -There were no instructions on the eMAR to obtain blood pressure and pulse prior to the administration of metoprolol. -There was no documentation on the eMAR that Resident #5's blood pressure and pulse was checked prior to administration of metoprolol. -Blood pressure readings were recorded daily from 09/01/18 to 09/30/18 except 09/26/18 at 6:00am. -The SBP ranged from 102-208 and the DBP ranged from 43-118. Review of Resident #5's October 2018 eMAR revealed:	D 276		

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D 276	Continued From page 12 -A computer generated entry for metoprolol 25mg take 2 tablets two times daily for hypertension scheduled to be administered at 8:00am and 8:00pm. -Metoprolol was documented as administered from 10/01/18 to 10/19/18. -There were no instructions on the eMAR to obtain blood pressure and pulse prior to the administration of metoprolol. -There was no documentation on the eMAR that Resident #5's blood pressure and pulse was checked prior to administration of metoprolol. -Blood pressure readings were recorded daily from 10/01/18 to 10/09/18 at 6:00am. -The SBP ranged from 103-180 and DBP ranged from 55-87. Interview with the Medication Aide (MA) on 10/10/18 at 10:20am revealed: -She did not know Resident #5's blood pressure and pulse was supposed to be checked before administration of metoprolol. -She had never checked a resident's pulse and only checked a blood pressure if a resident complained that they were not feeling well. -She was never alerted to enter Resident #5's blood pressure and pulse in the eMAR software. -The Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD) were responsible for entering new orders on the eMAR. Interview with the RCC on 10/11/18 at 12:16pm revealed: -She knew that Resident #5's blood pressure and pulse needed to be checked daily. -The MAs were responsible for entering new orders in the computer for the eMAR. -She and the HWD processed orders if the MAs were too busy when a new order was received. -The MA was responsible for correctly entering	D 276		

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the medication order and the order for monitoring into the eMAR when they received the order for metoprolol for Resident #5.
-The MA was responsible for setting up the eMAR to prompt for blood pressure and pulse readings if needed.
-The eMAR was supposed to be set up to prompt the MA to enter the blood pressure and pulse into the computer before they document that the medication was administered.
-The HWD or RCC would audit eMARs and resident records every 3 months unless a resident had a significant change.

Interview the HWD on 10/10/18 at 11:38am revealed:
-She or HWD were responsible for processing new physician orders including new FL2s and hospital discharge summaries.
-If a new order came in after hours, the MA was responsible for reconciling medications and sending order clarifications to the physician.
-She, the RCC, or a MA would enter a new order into the computer depending on when the order was received.

Interview with the Administrator on 10/11/18 at 11:52am revealed:
-The HWD and RCC were responsible for entering all new orders into the computer for the eMARs.
-The HWD or RCC should enter a new order into the computer and the other person verify the order.
-The HWD was on-call 24 hours a day if a new order came in after hours and the MA had a question.

Telephone interview with a representative at Resident #5's Primary Care Physician's (PCP)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036013	A. BUILDING: _____ B. WING _____	R 10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NEW HOPE	1680 SOUTH NEW HOPE ROAD GASTONIA, NC 28054

(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 276	Continued From page 14 office on 10/11/18 at 10:29am revealed: -The PCP's office did not know that Resident #5 was not being properly monitored regarding his blood pressure medication. -The staff should be checking Resident #5's blood pressure and pulse prior to administering a dose of metoprolol. -Blood pressure should be obtained immediately before dose was given. -If Resident #5's blood pressure and pulse was not checked and the medication was given to the resident then it could drop his blood pressure and pulse to dangerous levels.	D 276		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services that are adequate, appropriate and in compliance with federal and state laws and rules and regulations related to health care and medication administration. The findings are: Based on interviews and record reviews, the facility failed to notify the physician for 1 of 5 sampled residents (Resident #5) related to blood	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 15 pressure readings outside ordered parameters. [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		