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
	HAL092032	A. BUILDING: _____ B. WING _____	R 03/21/2019

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BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on March 19-21, 2019.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 6 sampled staff (Staff A and F) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) according to G. S. 131E-256. The findings are: 1. Review of Staff A's personal file revealed: -She was hired on 06/09/15 and worked as a Program Coordinator. -There was no documentation of a HCPR documentation check in Staff A's personal record. Interview on 03/21/19 at 9:05 am with Staff A revealed: -She worked in the Special Care Unit (SCU) doing memory care training and resident feeding assistance techniques. -She sometimes assisted with resident dressing, transferring, and toileting. -She did not know HCPR documentation was	D 137	***All staff will have a Health Care Personnel Registry verification. An audit of all associate files was completed on 4/29/19 and all associates have a completed verification in their current file.***	4/29/19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 4/29/19

Received & accepted with amendment p. 41 4/30/19 Edwards

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D 137	Continued From page 1 missing in her personnel record; she did not know she needed to have a HCPR check upon hire. -The Business Office Manager (BOM) handled staff personnel records. Refer to interview on 03/21/19 at 3:40 pm with the BOM. Refer to interview on 03/21/19 at 4:30 pm with the Health and Wellness Coordinator (HWC). 2. There was no personnel record available for review for Staff F in the business office. Interview on 03/21/19 at 12:10 pm with Staff F revealed: -He did not have a personnel file at the facility; he was contracted by the corporate office 15 years ago to be a transitional dietary manager and cook for their dietary departments. -There was currently no Dietary Manager at the facility; he was sent to work 2-3 days a week in the dietary department. -His personnel records, including documentation of a HCPR check, were in the corporate office; he did not bring his personnel records with him to this facility. Interview on 03/21/19 at 3:40 pm with the BOM revealed: -The HCPR check for Staff A was missing from her staff records. -There was no HCPR documentation for Staff F; his personnel records were not in the facility, they were in the corporate office; she would call the corporate office to get Staff F's personnel records. -She was responsible for assuring staff personnel records were complete.	D 137		

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D 137	Continued From page 2 Interview on 03/21/19 at 4:30 pm with the Health and Wellness Coordinator (HWC) revealed: -She did not know the HCPR document was missing from Staff A's personnel record. -Staff F's personnel records were not in the facility; they were at the corporate office. -The BOM was responsible for assuring staff documents were in their staff records. Attempted telephone interview on 03/21/19 at 4:40 pm with the Administrator was unsuccessful. Review of the HCPR check for Staff A obtained on 03/21/19 by the BOM reveled no substantiated findings. No HCPR check for Staff F were received by the end of the survey.	D 137	*Surveyor was informed the Administrator was not available during the course of the survey. The community had a covering administrator-in-charge during the course of the survey who was on site and available to speak with the surveyor.*	
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on interviews and attempted record review, the facility failed to assure 1 of 6 sampled staff (Staff F) had a criminal background check completed in accordance with G. S. 114-19-10 and 131D-40. The findings are: There was no personnel record available for review for Staff F in the business office.	D 139	*Staff F did have a completed criminal background check in accordance with G.S. 114-19.10 and 131D-40. The facility is not required to maintain a copy of the completed criminal background check at the facility. Staff F is an Associate Director of Dining who floats between facilities in that role as an employee of the Brookdale Senior Living corporate office. The criminal background check for Staff F was completed through the corporate office prior being assigned at Brookdale Wake Forest.*	1/3/07 Additional Criminal Background Screen done 3/27/19

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D 139	Continued From page 3 Interview on 03/21/19 at 12:15 pm with Staff F revealed: -He was contracted by the corporate office 15 years ago to be a transitional dietary manager and cook for facility dietary departments. -He did not have a personnel file containing a criminal background check at the facility. -His personnel records, including documentation of a criminal background check, were in the corporate office; he did not bring his personnel records with him to this facility. Interview on 03/21/19 at 4:00 pm with the BOM revealed: -There were no personnel records in the facility to review for a criminal background check for Staff F. -Staff F's personnel records were at the corporate office since he was assigned to travel to different facilities as needed. -She had not received a personnel record for Staff F from the corporate office today. -She was responsible for assuring all staff records were complete and accessible. Attempted telephone interview on 03/21/19 at 12:25 pm with the Administrator was unsuccessful. No criminal background check documentation for Staff F was received by the end of the survey.	D 139	*Surveyor was informed the Administrator was not available during the course of the survey. The community had a covering administrator-in-charge during the course of the survey who was on site and available to speak with the surveyor.*	
D 150	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency	D 150		

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D 150	Continued From page 4 (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 5 sampled staff (Staff A) who provided personal care to residents, successfully completed an 80-hour personal care training and competency program. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired on 06/09/15 as a Program Coordinator (PC). -There was no documentation of Staff A having completed an 80-hour personal care training and competency program. Interview on 03/21/19 at 4:45 pm with the PC revealed:	D 150	*Staff A will complete an 80 hour training and competency evaluation by June 30, 2019. An audit will be conducted by the Executive Director (ED) or designee of direct care staff training to verify completion of the 80-hour training and competency evaluation program. To assist with ongoing compliance, the ED or designee will audit the associate files to verify the 80-hour training and competency evaluation program completion, monthly for three (3) months*	

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D 150	Continued From page 5 -She had not completed an 80-hr. personal care training and competency program. -She did not think she needed to have the training. -No one asked her to take personal care training. -She assisted with residents activities, took residents on outings, and had assisted residents with transferring and going to the bathroom. -The Business Office Manager (BOM) kept her staff records in the office. -The Administrator was responsible for having the personal care training and competency documentation in her staff record. Interview on 03/21/19 at 3:40 pm with the BOM revealed: -She did not know documentation of Staff A having completed an 80-hour personal care training and competency program was missing from the staff's personnel record. -She did not know Staff A needed the personal care training for the PC position; she had not been told Staff A needed personal care training. Attempted telephone interview on 03/21/19 at 3:50 pm with the Administrator was unsuccessful.	D 150	*Surveyor was informed the Administrator was not available during the course of the survey. The community had a covering administrator-in-charge during the course of the survey who was on site and available to speak with the surveyor.*	
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of	D 161		

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D 161	Continued From page 6 Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 5 sampled staff (Staff A) were competency validated for Licensed Health Professional Support (LHPS) tasks. Review of Staff A's personnel record revealed: -Staff A was hired on 06/09/15 as a Program Coordinator (PC). -There was no documentation of an LHPS competency validation. Interview on 03/21/19 at 3:40 pm with the PC revealed: -She had not been LHPS competency validated; she did not think she needed to be checked off for LHPS tasks, no one asked her to be LHPS competency validated. -There would be no LHPS competency validation documentation in her personnel record. -She assisted residents with transferring and ambulating to the bathroom at times. -The Administrator was responsible for having LHPS competency validation documentation in her staff record. Interview on 03/21/19 at 1:05 pm with the LHPS nurse revealed: -Staff A was working at the facility before she started doing LHPS validations for staff. -She did not know if Staff A had been LHPS	D 161	***An audit will be conducted by the Executive Director (ED) or designee of care associate personnel files to determine if their practice act and occupational licensing competency validation is in their personnel file. To assist with ongoing compliance, the ED or designee will audit the associate files to verify the practice act and occupational licensing competency validation, monthly for three (3) months."***	4/25/19

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D 161	Continued From page 7 validated; she was not asked to validate Staff A. Interview on 03/21/19 at 3:45 pm with the Business Office Manager (BOM) revealed: -She did not know LHPS validation documentation was missing from Staff A's personnel record. -She was responsible for assuring the LHPS validation documents were in Staff A's personnel record. Attempted telephone interview on 03/21/19 at 3:50 pm with the Administrator was unsuccessful.	D 161	***Surveyor was informed the Administrator was not available during the course of the survey. The community had a covering administrator-in-charge during the course of the survey who was on site and available to speak with the surveyor.***	
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions;	D 164	***Staff B did complete the required Care of Diabetic Residents training on May 31, 2018. While the Certificate of Completion was not in Staff B's file at the time of the above referenced survey, it was determined that the documentation was placed in the personnel file of the facility associate who conducted the training. The Business Office Coordinator (BOC) will be retraining by the Executive Director (ED) or designee on April 26, 2019, as to how to track and maintain the appropriate training logs and training certificates of completions.***	5/31/18

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D 164	Continued From page 8 (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled medication aides (Staff B) had completed training on the care of diabetic residents prior to obtaining fingerstick blood sugars and administering insulin. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 04/18/18 as a medication aide/personal care aide (MA/PCA). -There was no documentation of training on the care of the diabetic resident. Interview on 03/21/19 at 6:25 pm with Staff B revealed: -She performed finger stick blood sugars (FSBS) and administered insulin to residents with diabetes. -She completed diabetic care training (did not remember the date) and her documentation of the training should be in her personnel record. -She did not know the documentation for diabetic training was not in her personnel record. -The Business Office Manager was responsible for assuring her training documents were in her personnel record. Review of a resident's medication administration records (MAR) for February and March, 2019 revealed: -The resident had a physicians's order for FSBS and sliding scale insulin 3 times a day. -Staff B was documented as obtaining FSBS 6	D 164		

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D 164	Continued From page 9 times and administering insulin 2 times to the resident. Interview on 03/21/19 at 4:47 pm with the BOM revealed: -She did not know Staff B's diabetic care training documentation was not in her personnel record. -She was responsible for assuring staff training records were in their personnel record. Interview on 03/21/19 at 4:55 pm with the Health and Wellness Director (HWD) revealed: -The BOM was responsible for assuring Staff B's training records were in her personnel record. -An audit of personnel records should be done to assure staff records were complete. Attempted telephone interview on 03/21/19 at 4:59 pm with the Administrator was unsuccessful.	D 164	*Surveyor was informed the Administrator was not available during the course of the survey. The community had a covering administrator-in-charge during the course of the survey who was on site and available to speak with the surveyor.*	
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION	D 270		

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D 270	Continued From page 10 Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 of 2 sampled residents (Resident #1) who was disoriented and ambulatory resulting in repeated falls. The findings are: Review of Resident #1's current FL2 dated 12/12/18 revealed: -Diagnoses included dementia, vertigo, and osteoporosis. -Resident #1 was intermittently disoriented. -Resident #1 needed assistance with bathing. -Resident #1 was ambulatory with no assistance needed for ambulation. Review of Resident #1's Resident Register revealed an admission date of 12/11/18. Review of Resident #1's and current Care Plan dated 02/12/19 revealed: -"Resident uses a walker with ambulation around the Unit. She has had recent falls without injury. Resident is forgetful about always using her walker and at times will leave it behind. Resident continues to receive PT [physical therapy]. Goal: monitor for changes in gait, safety awareness". -Resident #1 "is not always oriented to place" and "is not always oriented to time". -Resident "is forgetful but understands others and is making her needs know at this time." Review of Resident #1's "Post-Fall Evaluation Forms" generated by the facility's Health and Wellness Director (HWD) revealed: -There were no documentation for falls on 01/19/19 and 12/30/18. -There was documentation of 8 unwitnessed falls and 2 witnessed falls from 02/02/19 through	D 270	***All residents are assessed by the HWD or designee for risk of falls on move in, at six (6) month intervals and after falls. Six (6) month assessments are located within the PSP (Care plan). Interventions for residents with increased personal care and supervision needs will be entered on the resident service plan and added to the assignment sheet by the HWD or designee. These interventions may include but are not restricted to increased monitoring, PT/OT, medication reviews and consults with other providers. Increased monitoring following a fall will occur every 30 minutes for 24 hours, every 1 hour for 24 hours and every 2 hours for 24 hours for 72 hours total. Residents who continue to have falls will be assessed by their physician for a higher level of care. Residents determined to need one to one supervision for any reason will be notified as well as their legal representative and a companion will be required until discharged from the community or determined by their physician to no longer need the one to one supervision. Any interventions will be documented in the resident record by the HWD or designee. To assist with ongoing compliance, the HWD or Designee will monitor and review charting monthly for three (3) months***	4/29/19

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D 270	Continued From page 11 03/20/19. -One of the witnessed falls was documented as occurred with a physical therapist. -One of the witnessed falls was documented as occurred in the dining room. -The eight unwitnessed falls occurred in the resident's room; five falls near her bed, 1 fall near the bathroom, 1 fall in the dining room, and one near the bedroom closet. -None of the falls resulted in the resident being transferred out for medical evaluation. -On 02/02/19 at 1:00 am, Resident #1 was found in room sitting on the floor close to closet. "Resident shoes seem to be too big". "Encourage resident to ask for help and use emergency call system" was documented. No apparent injury. -On 02/10/19 at 2:25 am, Resident #1 was found sitting on the floor. Resident stated she was going to the bathroom. The medication aide (MA) had just checked the resident was documented on the form. "Shoes seem to be too big" was documented under describe poor fitting shoes. No apparent injury. -On 02/18/19 at 12:50 pm, Resident #1 sat down on the floor in the dining room. Resident had walker. The fall was witnessed by a staff member. No apparent injury. -On 02/19/18 at 10:20 pm, Resident #1 was found sitting on the floor in her bedroom near the bed. Resident stated she was going to the bathroom. No apparent injury. -On 02/23/19 at 8:17 pm, Resident #1 was found lying on the floor near her bed. No apparent injury. -On 02/25/19 at 11:15 am, Resident #1 fell to her knees in room close to the bathroom during physical therapy session. Medications were adjusted by Physician Assistant (PA). No apparent injury. -On 02/26/19 at 7:20 am, Resident #1 was found	D 270		

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D 270	Continued From page 12 on her right side near her bed. Resident stated she was trying to go to the bathroom without her walker. -On 02/28/19 at 3:00 am, Resident #1 was found sitting on the floor at the foot of the bed. Resident was trying to go to the bathroom, not using her walker. The medication aide had just left room 5 minutes before finding resident. No apparent injury -On 03/01/19 at 6:38 am, Resident #1 was found sitting on the floor (no location documented). Resident stated she was going to try to get something out of the closet. No apparent injury. -On 03/08/19 at 1:30 am, Resident #1 was found near her bed sitting on the floor. Resident stated she was going to the bathroom. No apparent injury. Review of Resident #1's record revealed: -There was a physician fax sheet for fall notification documenting a fall with no injury on 01/19/19 at 8:30 am. -There was no information available regarding the time of the fall, or if the fall was witnessed or unwitnessed. -There was no Post-Fall Evaluation Form available for review for the fall on 01/19/19. -There was no documentation of the fall noted in the resident's progress notes. Review of Resident #1's progress notes revealed: -There was a fall documented on 12/30/18 with no injury. -There was no Post-Fall Evaluation Form documented by the facility staff for the fall on 12/30/18. -There was no information available regarding the time of the fall, or if the fall was witnessed or unwitnessed. -"Monitor closely" was noted in the progress on	D 270		

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D 270	Continued From page 13 12/30/18. -"Resident (#1) had a fall on 02/10/19, she is being monitored" was documented. -On 02/20/19 at 7:09 am, "Note Text: resident had a fall on 02/18 and 02/19 resident is being monitored at hours". -On 02/26/19 at 10:42 pm, "Note Text: Resident continues to get out of bed and walk around. (Staff) sat in with her until she went to bed". -On 02/27/19 at 6:34 am, "Note Text: resident had a fall on 02/26/19 no injuries resident is to be monitored very closely" -There was no documentation for the frequency of additional or increased supervision subsequent to the resident's falls in the progress notes. Review of Resident #1's record revealed: -There was documentation for completed urine swabs (to check for urinary tract infection) ordered on 02/07/19, 02/21/19 and 02/26/19. -There was documentation the resident had physical therapy (PT) from 12/27/18 to -The resident was seen by PT for functional transfers, stamina strengthening, and self care task. -Resident #1 was discharged on 03/17/19 "as maximum potential met, with discussion with family and Physician's Assistant (PA) for use of a wheelchair when she is not able to walk". Interview with Resident #1's PA on 03/21/19 at 10:00 am revealed: -She saw Resident #1 every week during her weekly routine visits. -Resident #1 had a lot of falls and she wanted to check the resident as well as try to evaluate treatment options. -She ordered a test for urinary tract infection on 3 occasions in February 2019. -She added medications for anxiety and agitation	D 270		

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D 270	Continued From page 14 but changed the medications 2 times in the event the medication might be adding to the falls. -Resident #1 had complained of knee pain so she had ordered X-rays to rule out knee injury. -She ordered a mild pain reliever for knee pain to be administered routinely; but not so strong as to possibly contribute to falls. -The resident had physical therapy until goals were met and she was discharged on 03/17/19. -Using a wheelchair on days when she was unsteady or not able to stand was discussed. -Lastly, she ordered a medication to help with urinary urgency and frequency at night to help the resident not to need to go to the bathroom during the night. -She did not know how frequently the facility staff checked on residents or if the facility had increased their supervision for Resident #1 to assist with preventing the resident from trying ambulate without her walker. -Increasing the supervision of Resident #1 could be another aide in preventing falls. -She had not ordered increased supervision. Interview with the Resident Care Coordinator (RCC) on 03/21/19 at 12:15 pm revealed: -The Health and Wellness Director (HWD) was responsible to evaluate residents for the need for extra care or increased supervision. -She knew Resident #1 was considered as needing a full time sitter at a conference with the family at the end of February 2019 due to the increased falls and the resident not being compliant with using her walker. -She was not responsible to assign staff to provide increased supervision to a resident. Interview with the HWD on 03/21/19 at 1:15 pm revealed: -She was aware Resident #1 had multiple falls	D 270		

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D 270	Continued From page 15 since admission in December 2018. -She was responsible for completing the "Post-Fall Evaluation Form" and entering the falls information into the facility's computer tracking system. -She had evaluated the falls trying to isolate a particular time the resident was falling, but it seemed it was both day and nighttime. -Resident #1's falls seemed to be occurring because the resident did not call for assistance when getting out of bed or moving from one place to another, and not remembering to use her walker due to her diminishing cognitive state. -The facility did not use chair or bed alarms because they were considered restraints by the Corporate Office and the facility was restraint free. -Resident #1's PA had been notified for each fall and had been involved with changing medications, ordering urine analysis for possible urinary tract infections (a leading cause for weakness or changes in cognitive status) and continuing physical therapy. -Resident #1 had developed the need for increased personal care with toileting, and reminders for using walker from ambulating. -Staff were assisting Resident #1 with using her her walker for transfers from chairs or the bed and reminding her to use her walker. -There had been a meeting with the Resident #1's family in a change to the Care Plan meeting at the end of February 2019 to discuss options for decreasing falls, including possibly a full time sitter to supervise the resident, but the family did not want to use a sitter at this time. -The facility agreed to monitor falls a "little longer" (no specific length of time was given) before requesting a sitter for the resident. -Resident #1's shoes were changed to fit better and be non-skid.	D 270		

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D 270	Continued From page 16 -Resident #1's family had assisted in removing clutter from the resident's room. -Facility staff routinely checked on residents every 2 hours or more often if a resident had incontinence episodes. -The facility did not have additional staff to provide one on one supervision for Resident #1. -The facility did not document increased supervision, except in the progress notes entered into the facility's computer system. -The facility staff had been instructed to check on Resident #1 more often than every 2 hours but there was no documentation of how often staff checked on the resident. -The facility did not have a policy for routinely increasing supervision for a designated period of time after falls. Interview with a medication aide (MA) on 03/21/19 at 3:15 pm revealed: -She routinely worked in the Special Care Unit (SCU) where Resident #1 resided. -Resident #1 had been falling a lot but had not had an injury. -Resident #1's legs seem to be very weak. -Resident #1 requested to go to the bathroom a lot, and sometimes would not wait for staff to assist her with getting up using her walker. -Resident #1 needed prompting to remember her walker. -Resident #1 was up and down out of bed a lot in the evening, saying she needed to go to the bathroom. -Resident #1 had been tested but did not have a urinary infection. -She did not know of any facility policy to increase supervision for a resident after a fall. -She came up with the idea to put a chair outside Resident #1's room when she worked evening shift and watch the resident in case she decided	D 270		

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D 270	Continued From page 17 to get up without using the call bell to request staff. -After she made her rounds, she would watch the hall from the chair outside Resident #1's room until time for the next rounding. -There was no place other than the computer progress notes to document information for residents. -She did not document each time she sat outside the door of Resident #1's room. Telephone interview with Resident #1's family member on 03/21/19 at 5:00 pm revealed: -Resident #1 had fallen a few times at home before coming to the facility. -He was notified when the resident fell. -He was aware Resident #1 had a lot of falls. -He thought Resident #1's knees were giving away was the reason she had most of the falls. -Most of the fall were in February 2019. -Resident #1 seemed to have had a decline in her cognitive ability in February. -The facility had involved the family with helping to re-arrange furniture, removing any clutter that was in the room, and getting better fitting shoes. -Resident #1 had been routinely seen by physical therapy since coming to the facility. -He had met with the facility about 3 weeks ago regarding an increase in Resident #1's care needs and the frequent falls. -He did not know how often the facility checked on Resident #1 but he felt they were doing the best they could to prevent her falling. -The resident had not fallen, to his knowledge, since 03/08/19. Attempted telephone interview on 03/21/19 at 4:50 pm with the Administrator was unsuccessful. The facility failed to provide increased supervision	D 270	*Surveyor was informed the Administrator was not available during the course of the survey. The community had a covering administrator-in-charge during the course of the survey who was on site and available to speak with the surveyor.*	

Division of Health Service Regulation

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D 270	Continued From page 18 for a resident with dementia diagnosis (#1) who experienced multiple repeated falls placing the resident at increased risk for injury from falls. This 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 03/21/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 5, 2019.	D 270		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to keep the kitchenand food storage areas clean and free from contamination. The findings are: Observation on 03/20/19 at 7:26 am of the kirchen floor revealed: -There were small puddles of water, bits of paper, and food crumbs on the floor in the room. -There was a build-up of dark brown dust particles and food crumbs on the floor tiles and base board tiles in the corners and around the	D 282	*Kitchen cleaning schedule developed and implemented on March 20, 2019. Kitchen staff was re-trained on March 25, 2019 on following cleaning schedule on an ongoing daily basis. To assist with ongoing compliance the ED or designee with review the cleaning schedule monthly for three (3) months*	3/25/19

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D 282	Continued From page 19 floor in the room. Observation on 03/20/19 at 7:30 am of the kitchen revealed there were yellow stains on all 4 walls. Observation on 03/20/19 at 7:27 am of the dishwasher area revealed: -There was a build-up of dark brown dirt and dust, trash,, and crumbs on the floor under the dishwasher. -There were black and yellow stains on the wall and doorway frame beside the dishwasher. -There was a build-up of gray and yellow brown dust particles around and on the floor drain under the dishwasher. -There yellow grease smears and brown stains on the lid of the trash can beside the dishwasher. Observation on 03/20/19 at 7:30 am of the tray storage rack revealed the wheels and metal shelves were coated with corrosion and food crumbs; there were food crumbs and dust particles inside the open box of plastic food wrap on a shelf of the storage rack. Observation on 03/20/19 at 7:32 am of a second storage rack beside the walk-in cooler revealed: -The frame bars of the storage rack were rusted and the metal shelving was coated with sticky dust particles. -There was a build-up of a white hard substance on a hammer lying on the shelf. Observation on 03/20/19 at 7:33 am of the walk-in cooler revealed: -There were dark brown and yellow stains on the door above and below the door handle and the door frame. -There were brown stains and bits of torn paper	D 282		

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D 282	Continued From page 20 and crumbs on the floor of the cooler. -There was a build-up of tan dust particles in the corners and the entry to the cooler. -There were brown stains on the lids of the plastic containers on the floor. -There were food crumbs, sticky brown food splatters, and dust particles in the trays containing plastic gallon bottles of liquids. Observation on 03/20/19 at 7:36 am of the kitchen stove revealed: -There was a build-up of greasy food crumbs on the cook top between the burners. -There was a black, yellow and white substance coating the flooring tiles behind the stove. -There were yellow greasy splatter marks on the side of the stove. Observation on 03/20/19 at 7:38 am of the walk-in freezer revealed: -There were dark brown and yellow stains on the door above and below the door handle and the door frame. -There were brown stains and bits of torn paper and crumbs on the floor of the freezer. -There was a build-up of tan dust particles in the corners and the entry. -There was a coating of a yellow sticky substance on the storage racks. -The wheels of the storage racks were coated with an unknown white and green substance; the metal top caps of the wheels were corroded. -There were food crumbs and bits of paper in the food storage trays. -There was a build-up of dust particles on the 2 round ventilation fans attached to the ceiling at the back of the freezer. Observation on 03/20/19 at 7:40 am revealed:	D 282		

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D 282	Continued From page 21 -There was a grease spattered "Cleaning Schedule" hanging on the back wall of the kitchen titled "Week of: 7 - 9". - There was a listing down the left side of cleaning assignments; there were staff initials beside the assignments on Monday and Tuesday, there were no initials on the assignments for the rest of the week days. Interview on 03/21/19 at 2:45 pm with the Cook revealed: -There was not a full-time Dietary Manager for the facility; the prior manager left 02/01/19. -"After he left , kitchen staff tried to clean when we could, the kitchen was short staffed." -"We had a corporate dietary manager come to assisst for 2 days a week to assist with cooking." -"The prior manager did not schedule serious cleaning times, we need to have a new cleaning system started." Interview on 03/20/19 at 11:30 am with Staff F, Dietary Manager, revealed: -The facility had been without a dietary manager for about 3 weeks. -He was assigned to come to the facility for 2 days this week to do food orders, go over the menus, manage staffing and do staff training; he was also doing some of the cooking. -He did not know how the cleaning was done before he came. -Definitely there were some cleaning concerns; power washing and thorough cleaning needed to be done. Attempted telephone interview on 03/20/19 at 12:15 pm with the Administrator was unsuccessful.	D 282	*Surveyor was informed the Administrator was not available during the course of the survey. The community had a covering administrator-in-charge during the course of the survey who was on site and available to speak with the surveyor.*	

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D 299	Continued From page 22	D 299		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 8 ounces of milk was served twice daily to the residents. Observation on 03/19/19 at 5:38 pm of the kitchen's refrigerator revealed: -There were 8 full gallons of milk and 1 half full gallon of milk on the shelf. -The facility census was 35; 4.38 gallons would be required to serve all residents two, 8 ounce gallons of milk per day. Review of the Daily Diet Modification Summary Report for 03/19/19 revealed 8 ounces (1 cup) of milk was to be served to the resident at the breakfast and dinner meals. Observation of the assisted living dinner meal on 03/19/19 from 5:03 pm to 5:40 pm revealed: -There were 23 residents seated in the dining room. -All residents were served glasses of iced tea and water; 3 residents were served glasses of milk.	D 299	*Milk is available at breakfast and dinner for all residents. HWD or designee to determine which residents who do not want milk during meals will have a note on their care plan by May 31, 2019.*	

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D 299	Continued From page 23 -Milk was not not offered or served to the other 20 residents at dinner. Interview on 03/19/19 at 5:05 pm with 4 residents seated at table #1 revealed: -Two of the residents were brought milk because the staff knew they liked milk at meals, they did not ask for the milk. -The other 2 residents were not offered or served milk to drink with their meal; 1 resident wanted to have milk to drink. Interview on 03/19/19 at 5:10 pm with 4 residents seated at table #2 revealed they were not asked or offered milk to drink with their meal. Interview on 03/19/19 at 5:12 pm with 5 residents seated at table #3 revealed: -One resident was brought milk to drink with her meal because she had a physician's order to be served milk at all meals. -The other 4 residents were not offered milk; 2 residents would like to have milk to drink with their meal. Interview on 03/19/19 at 5:15 pm with 4 residents seated at table #4 revealed they were not asked or offered milk to drink with their meal; 1 resident wanted to have a glass of milk to drink. Interview on 03/19/19 at 5:20 pm with 4 residents seated at table #5 revealed they were not asked or offered milk to drink with their meal; 1 resident wanted to have a glass of milk to drink. Interview on 03/19/19 at 5:25 pm with 2 residents seated a table #6 revealed they were not asked or offered milk to drink with their meal; 1 resident wanted to have a glass of milk to drink.	D 299		

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D 299	Continued From page 24 Interview on 03/19/19 at 5:30 pm with a personal care aide (PCA) assisting with the meal service revealed: -Milk was served to residents who requested to have a glass of milk at their meal. -"If we knew a resident liked milk or had a physician's order to be served milk at meals, they would receive a glass of milk." -No one told her to serve milk at the dinner meal. Interview on 03/19/19 at 5:24 pm with a dietary cook revealed: -She did not know milk was on the dietitian's menu to be served twice a day. -She cooked and plated the meals, she did not serve the meals and beverages to the residents. -She was aware a cart was prepared for the SCU residents; a gallon of milk and glasses were placed on the cart to be served to all of the SCU residents at meals. Observation on 03/19/19 from 5:30 pm to 6:00 pm of the SCU dining room revealed: -There were 10 SCU residents seated for dinner in the dining room. -No residents were served or offered milk to drink with their dinner meal. -There was a 1/2 gallon of milk on the beverage cart with 5 glasses. -All residents were served water and tea to drink. -No SCU resident was offered or served milk during the dinner meal. Interview on 03/19/19 at 5:35 pm with a PCA revealed: -"If a resident likes it (milk), they (staff) provide it". -She was not sure which residents liked milk. Interview on 03/19/19 at 5:24 with a medication	D 299		

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D 299	Continued From page 25 aide (MA) revealed: -The residents did not have milk to drink for the evening meal; milk was served with breakfast. -He knew a glass of milk was to be served to all residents at a meal, but did not know milk was to be served twice a day with meals; he had not looked at the dietitian's menu. Interview on 03/20 at 8:45 am with the Program Coordinator revealed: -Staff were supposed to serve milk to residents 2 times a day; she was not aware the SCU residents were not served milk for dinner last night (03/19/19). Interview on 03/19/19 at 5:50 pm with the Resident Care Coordinator (RCC) revealed: -She did not read the dietitian's menus. -She did not know an 8 ounce glass of milk was to be served to all residents at breakfast and dinner. -She was not told milk was to be served to all residents twice a day at meals. Interview on 03/21/19 at 2:45 pm with the Cook revealed: -The former Dietary Manager (DM) left on 02/01/19; he did not serve meals according to the dietitian's menus. -Dietary staff were trained by the former DM and did not serve or offer milk to residents twice a day. -The DM was to train staff to read and follow the dietitian's menu. -Milk was to be served 2 times a day, to all residents, according to the dietician's menu. Attempted telephone interview on 03/19/19 at 6:00 pm with the Administrator was unsuccessful.	D 299	*Surveyor was informed the Administrator was not available during the course of the survey. The community had a covering administrator-in-charge during the course of the survey who was on site and available to speak with the surveyor.*	

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D 310	Continued From page 26	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure a therapeutic diet was served as ordered for 1 of 3 sampled residents in the Special Care Unit with a diet order for mechanical soft diet (Resident #6). The findings are: Review of Resident #6's current FL2 dated 11/20/18 revealed: -Diagnoses included unspecified dementia with behavioral disturbances. -There was an order for mechanical soft diet. Review of Resident #6's record revealed: -There was a facility "addendum to FL2" for Resident #6 listing available texture modified diet checked for the resident. -"The texture modified diet offers food that is moist and soft solid. All meats and poultry are ground with the exception being small tender	D 310	***An audit of all diet documentation will be completed by May 31, 2019 to verify diet orders are present and there is a corresponding therapeutic diet menu for each diet. The Diet Manual has been updated to reflect all current diets, alternatives and therapeutic needs. Direct Care staff will be re-trained by the HWD or designee, regarding requirements for therapeutic diets available in community by May 15, 2019. To assist with ongoing compliance, menus will be reviewed weekly by the Dining Services Manager or designee***	

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D 310	Continued From page 27 pieced of meat allowed in soups. It is expected that mixed textures are tolerated in this diet" was documented on the available diet form and checked for Resident #6. Review of Resident #6's physician order dated 12/13/18 revealed a texture modified diet was ordered. Review on 03/19/19 of the facility's diet type report posted in the kitchen for residents' diets revealed Resident #6 was to receive a texture modified diet. Review of the therapeutic diet list dated 03/19/19 revealed Resident #6 was to be served a texture modified diet. Review of the therapeutic diet menu for lunch on 03/19/19 revealed residents on a texture modified diet should be served ground barbeque pulled pork, tomato juice instead of tomato and cucumber plate, tomato juice instead of classic cole slaw, macaroni and cheese, a soft dinner roll and a smooth ice cream. Observation of the lunch meal service in the Special Care Unit (SCU) dining room on 03/19/19 from 12:00 pm to 12:30 pm revealed: -The meals were transported to the SCU already plated from the kitchen in the Assisted Living Unit. -Resident #6's plate was identified with a paper labeled with the resident's name and TEX MOD (texture modified) written on the paper. -The personal care aide served Resident #6 sweetened tea and water. -Resident #6 consumed none of the water and 2 glasses of tea. -Resident #6 was served barbeque pulled pork, tomato and cucumber with leaf lettuce on a small	D 310		

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D 310	Continued From page 28 salad plate, apple sauce instead of classic cole slaw, macaroni and cheese, a soft dinner roll and a smooth ice cream. -Resident #6 consumed 20 percent (%) of the barbeque pulled pork, the lettuce only for the tomato and cucumber with leaf lettuce on a small salad plate, 50% of apple sauce, 100% of macaroni and cheese, none of the soft dinner roll and 10% of the smooth ice cream. -Resident #6 did not cough or clear throat during the meal. Interview with the PCA serving Resident #6's meal on 03/19/19 at 12:15 pm revealed: -The kitchen staff prepared residents' meals, including plating the meals. -Residents' plates were sent to the SCU in the serving cart with each plate resting on a paper identifying the resident and the diet ordered. -She knew resident #6 did not received certain foods because she was on a textured modified diet. -She knew Resident #6 did not receive whole pieces of meat, and her plate sometimes had food substituted for food items residents on regular diets received. -Resident #6 received applesauce instead of cole slaw but the kitchen staff did the substitution. -She routinely served what was sent by the kitchen and labeled for each resident. Interview with the cook on 03/20/19 at 4:30 pm revealed: -He prepared Resident #6's lunch meal on 03/19/19. -He substituted applesauce for tomato juice because he thought the resident would like it better. -He chop the barbeque pulled pork a little but did not grind the pork in the food processor.	D 310		

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D 310	Continued From page 29 -He overlooked that he should not serve the tomato and cucumber with lettuce salad. Interview with the Dietary Manager on 03/21/19 at 11:40 am revealed: -The facility did not have a regular Dietary Manager at this time. -He worked for the Corporation as a floater Dietary Manager for several years now. -He was assisting with ordering food, cooking, and training dining staff until the facility hires a full-time Dietary Manager. -The cook should have followed the menu for preparing a texture modified meal for Resident #6. -Resident #6's barbequed pulled pork should have been placed in the food processor and chopped. -Resident #6 should not have received the tomato and cucumbers on the plate but tomato juice instead. -He was not sure why the resident received applesauce unless the facility was out of tomato juice. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview on 03/21/19 at 12:25 pm with the Administrator was unsuccessful.	D 310	*Surveyor was informed the Administrator was not available during the course of the survey. The community had a covering administrator-in-charge during the course of the survey who was on site and available to speak with the surveyor.*	
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for	D 344		

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D 344	Continued From page 30 medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 1 of 5 sampled residents (Resident #1) regarding an order for anti-anxiety/antidepressant medication. The findings are: Review of Resident #1's current FL2 dated 12/12/18 revealed: -Diagnoses included dementia, vertigo, and osteoporosis. -There was an order for Lexapro 10 mg at bedtime (used to treat anxiety and depression). Review of Resident #1's Resident Register revealed an admission date of 12/11/18. Review of Resident #1's physician's orders revealed:	D 344	***Physicians orders updated on eMAR on March 21, 2019. Mandatory retraining for all MA on completion and verification of new order tracking, and FL2 compliance will occur by May 14, 2019. HWD or designee will audit new order tracking form as orders are received for accuracy and verification for three (3) months***	

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D 344	Continued From page 31 -There was an order dated 02/25/19 to taper Lexapro with 5 mg daily for one week, then 5 mg every other day for one week, then stop. -There was an order dated 02/25/19 to start Effexor 37.5 mg daily on week 2 of the Lexapro taper. -There was a subsequent physician's order dated 03/07/19 to increase Effexor to 75 mg each day (from 37.5 mg) in one week, then continue at that dose. Review of Resident #1's March 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Effexor 37.5 mg one daily scheduled at 8:00 am daily. -Effexor 37.5 mg one daily was documented as administered from 03/07/19 to 03/19/19. -There was an entry for Effexor 75 mg one capsule daily scheduled at 8:00 am daily. -Effexor 75 mg one capsule daily was documented as administered daily from 03/15/19 to 03/19/19 (in addition to Effexor 37.5 mg). Telephone interview with the medical record staff for contract pharmacy on 03/21/19 at 11:46 am revealed: -Effexor 37.5 mg was dispensed for Resident #6 on 02/27/19 for a quantity of 16 capsules and on 03/13/19 for a quantity of 28 capsules. Both bubble packs were labeled for one capsule daily. -Effexor 75 mg was dispensed for a quantity of 28 on 03/15/19. Observation of medication on hand for administration for Resident #1 on 03/21/19 revealed: -There were twenty-one Effexor 37.5 mg tablets remaining from dispensing date 03/13/19 corresponding to one tablet administered daily for	D 344		

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D 344	Continued From page 32 7 days from 03/14/19 to 03/20/19. -There were twenty-two Effexor 75 mg tablets remaining from dispensing date of 03/15/19 corresponding to one tablet administered daily for 6 days from 03/15/19 to 03/20/19. Interview with a medication aide(MA)/Supervisor on 03/21/19 at 3:35 pm revealed: -The MA on duty when a medication order was received was responsible to enter the medication order in the computer eMAR system, fax the order to the pharmacy, place a copy of the order in the residents' records, and a copy in the new medication order tracking book for review by the Health and Wellness Director (HWD). -The MA was responsible to contact the physician to clarify medication orders when it was not clear if a current medication was discontinued when a new medication was started. -There was no specific order to discontinue Effexor 37.5 mg. -She did not question Resident #1 receiving 2 strengths of Effexor because other residents had received that dose and/or were receiving that dose. Review of Resident #1's record revealed there was no documentation Resident #1's provider had been contacted to clarify the physician's order dated 03/07/19 to increase Effexor to 75 mg each day in one week, then continue at that dose. Interview with the HWD on 03/21/19 at 4:00 pm revealed: -She had not reviewed Resident #1's medication orders for Effexor. -Upon reviewing the Effexor orders for the resident, she thought the order was for Effexor 37.5 mg to be discontinued and Effexor 75 mg	D 344		

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D 344	Continued From page 33 started on 03/15/19. -She was responsible to review residents' medication orders compared to the residents' eMARs routinely. -She had not done an audit for Resident #1 since her admission in December 2018. -She would contact the resident's Physician Assistant for the correct orders. Telephone interview on 03/21/19 at 4:45 pm with Resident #1's Physician Assistant (PA) revealed: -She had not been contacted regarding Resident #1's Effexor dose prior to today (3/21/19). -The facility called her to clarify the dose the PA wanted for Resident #1's Effexor. -The PA wanted a daily dose of 75 mg of Effexor for Resident #1. -She thought the initial order was clear. -She would sent an order to the facility to discontinue Effexor 37.5 mg and continue Effexor 75 mg daily. -Because the medication had a wide dosing range and could be increased in four to five day intervals, she did not expect Resident #1 would have any unwanted side effects for receiving the extra 37.5 mg for 6 days. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 344		
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.	D912		

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D912	Continued From page 34 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and regulations as related to supervision. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 of 2 sampled residents (Resident #1) who was disoriented and ambulatory resulting in repeated falls. [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal care and Supervision (Type B Violation)].	D912	*The community shall verify that residents receive appropriate care and services in accordance with federal and state laws, rules and regulations through oversight, supervision, training and assessment/identification of care, medication, nutritional and/or safety needs. Oversight and supervision will be provided by Executive Director, Health and Wellness Director, Resident Care Coordinator, RN Case Manager, Supervisors and/or Designee(s). Direct care associates will be retrained by the HWD or designee by May 31, 2019 on Resident Rights*	
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the	D934		

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D934	Continued From page 35 continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 3 staff sampled (Staff C, and D) who had been working for a least one year as Medication Aides (MA) received the annual state approved infection control training. The findings are: 1. Review of Staff C, MA's, personnel record revealed: -Staff C was hired 07/24/14 as a medication aide supervisor. -There was documentation Staff C completed the annual state approved infection control training 04/20/16. -There was no documentation for completion of the annual state approved infection control training for 2017 or 2018. Interview with Staff C on 03/21/19 at 4:22 pm revealed: -She did not know her training records were not in her folder. -She had done an infection training in 2018 but did not know the date. -The Business Office Manager kept staff records in her office.	D934	***Staff C and D did complete the required Annual State Approved Infection Control training. Staff C and D completed the training on May 31, 2018. While the Certificate of Completion was not in Staff C's or D's file at the time of the above referenced survey, it was determined that the documentation was placed in the personnel file of the facility associate who conducted the training. The Business Office Coordinator (BOC) will be retraining by the Executive Director (ED) or designee on April 26, 2019, as to how to track and maintain the appropriate training logs and training certificates of completions.***	5/31/18

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D934	Continued From page 36 Interview with the Business Office Manager (BOM) on 03/21/19 at 3:58 pm revealed: -The BOM had been in her present position for 2 years. -She was responsible to maintain staff records in her office. -There was no documentation available for review for Staff C annual infection control training subsequent to 04/20/16. Attempted telephone interview on 03/21/19 at 4:40 pm with the Administrator was unsuccessful. Refer to interview with a facility contract nurse on 03/21/19 at 1:05 pm. Refer to interview with the Health and Wellness Director (HWD) on 03/21/19 at 4:30 pm revealed: 2. Review of Staff D's, MA, personnel record revealed: -Staff D was hired in 06/03/08 as a medication aide. -There was documentation Staff D completed the annual state approved infection control training 04/20/16. -There was no documentation for completion of the annual state approved infection control training for 2017 or 2018. Interview with Staff D on 03/21/19 at 4:43 pm revealed: -The BOM was responsible for keeping all documentation for training. -He was sure the last date he had infection control but a copy of the training verification should be in his record. Attempted interview on 03/21/19 at 4:40 pm with the Administrator was unsuccessful.	D934	*Surveyor was informed the Administrator was not available during the course of the survey. The community had a covering administrator-in-charge during the course of the survey who was on site and available to speak with the surveyor.*	

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D934	Continued From page 37 Refer to interview with a facility contract nurse on 03/21/19 at 1:05 pm. Refer to interview with the Health and Wellness Director (HWD) on 03/21/19 at 4:30 pm. Interview with a facility contract nurse on 03/21/19 at 1:05 pm revealed: -She did medication aide clinical skills validations for medication aides when the facility requested her to validate a staff. -The BOM received documentation for any training from her. -She did not provide the annual state approved infection control training for the facility. Interview with the Health and Wellness Director (HWD) on 03/21/19 at 4:30 pm revealed: -The BOM was responsible for maintaining staff records for review, including all training training records. -The facility had a contract nurse that conducted training for medication aides. -She did not know MA staff had not completed annual infection control training.	D934		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in	D935		

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D935	Continued From page 38 an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interview and record review, the facility failed to assure 1 of 3 sampled	D935	*Staff B did complete the required Medication Administration (MA) 5 hour, 10 hour, and 15 hour training courses. While the Certificates of Completion were not in Staff B's file at the time of the above referenced survey, it was determined that the documentation was placed in the personnel file of the facility associate who conducted the training. The Business Office Coordinator (BOC) will be retraining by the Executive Director (ED) or designee on April 26, 2019, as to how to track and maintain the appropriate training logs and training certificates of completions.*	5/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	R 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

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D935	Continued From page 39 staff (Staff B), who administered medications, had employment verification or completed the 5, 10, or 15 hour medication administration training courses. The findings are: Review of Staff B's personal record revealed: -Staff B was hired on 04/18/18 as a medication aide/personal care aide (MA/PCA) -There was documentation Staff B passed the written medication exam on 02/09/18. -There was documentation Staff B was checked off on Medication Clinical Skills on 04/16/18. -There was no documentation Staff B completed the 5 hour, 10 hour, or 15 hour MA training. Review of a resident's March 2019 medication administration record (MAR) revealed Staff B administered medications on 7 days. Interview on 03/21/19 at 6:20 pm with Staff B revealed: -She completed the 15 hour medication training (did not remember the date). -She did not know the training documentation was missing from her personnel record. -The Business Office Manager (BOM) was responsible for having her training records in her personnel file. Interview on 03/21/19 at 1:05 pm with the Licensed Health Professional Support (LHPS) registered nurse (RN) revealed: -She did medication administration training for the MAs at the facility. -She taught the 15 hour course and checked off Staff B last May or June, 2018 (did not remember the date). -She gave Staff B's documentation to the BOM to	D935		

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D935	Continued From page 40 place in Staff B's personnel record; she gave all of her staff training documentation to the BOM. -She received no phone calls for a replacement copy of the 15 hour medication training for Staff B; she did not know the documents were missing. Interview on 03/21/19 at 4:45 pm with the BOM revealed: -She did not know Staff B's medication training documents were not in her personnel folder. -She was responsible for assuring staff records were complete in their personnel folder. -She would start an audit of staff personnel records to assure the records were complete. Attempted telephone interview on 03/21/19 at 4:50 pm with the Administrator was unsuccessful.	D935	*Surveyor was informed the Administrator was not available during the course of the survey. The community had a covering administrator-in-charge during the course of the survey who was on site and available to speak with the surveyor.*	
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to	D992	*Brookdale did not require associate drug screening prior to the effective date of the Drug and Alcohol Free Workplace policy dated 04/01/2006, and revised of 9/21/2007. Staff F was hired on January 3, 2007 which is prior to the implementation of this policy; therefore, Brookdale is not required to maintain a record of an examination and screening for the presence of controlled substances.*	1/3/07 amended correction date 3/28/18 by phone to EP. WE

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D992	Continued From page 41 the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and attempted record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 1 of 6 sampled staff (Staff F) hired after 10/01/13. The findings are: There was no personnel record for Staff F at the facility; there was no documentation for the examination and screening for the presence of controlled substances for Staff F. Interview on 03/20/19 at 12:00 pm with Staff F revealed: -There were no personnel records at this facility; his records were at the corporate office. -He worked for the company for 15 years providing management and cooking assistance to the dietary departments when needed.	D992		

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D992	Continued From page 42 -He would travel to a facility, as instructed, and work for 2-3 days a week depending on the assignment. -He did not carry his personnel records, with the documentation for examination and screening of controlled substances, with him to the facilities; the records stayed at the corporate office. Interview on 03/21/19 at 3:55 pm with the Business Office Manager (BOM) revealed: -Staff F was sent to this facility to assist in the dietary department. -There were no personnel records for Staff F at the facility. -She was responsible for having facility staff's personnel records complete and in her office. -All of Staff F's personnel records were at the corporate office; she did not know if he had an examination and screening for the presence of controlled substances. -She would contact the corporate office to have his records sent to the facility. Interview on 03/21/19 at 4:30 pm with the Health and Wellness Coordinator (HWC) revealed: -The BOM kept the personnel records in her office. -Staff F did not have a personnel record at the facility; there was no information on examination and screening of controlled substances at the facility. No documentation of an examination and screening of controlled substances for Staff F was received by the end of the survey. Attempted telephone interview on 03/21/19 at 4:40 pm with the Administrator was unsuccessful.	D992	*Surveyor was informed the Administrator was not available during the course of the survey. The community had a covering administrator-in-charge during the course of the survey who was on site and available to speak with the surveyor.*	

Edwards, Wanda A

From: astarresposito@brookdale.com
Sent: Monday, April 29, 2019 6:45 PM
To: Edwards, Wanda A
Subject: [External] RE: Brookdale Wake Forest 2019-04-05 SODBL 8C1Q11
Attachments: Brookdale Wake Forest 2019-03-21 POC.pdf

Dear Wanda,

Please see the attached Plan of Correction as a result of your State Survey March 19-21, 2019.

Please let me know if you have any questions.

Regards,
Allison Starr-Esposito
Executive Director
919-562-8400

--- Originally sent by wanda.edwards@dhhs.nc.gov on Apr 5, 2019 3:37 PM ---

Dear *Ms. Starr-Esposito:*

Please find the Statement of Deficiencies and accompanying letter for the annual and follow-up survey on March 21, 2019 attached to this e-mail. If the Statement of Deficiencies includes citations or violations for which a plan of correction is required, please read the attached letter carefully for instruction on completing the plan of correction. **PLEASE NOTE: WE WILL NOT ACCEPT A FAXED PLAN OF CORRECTION! We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted.** A response to the plan of correction will be sent ONLY if the plan of correction is not accepted. Please retain a copy for your files.

The attached letter also contains information regarding your right to request an Informal Dispute Resolution (IDR) of any cited deficiencies or violations. For more information about the IDR process please visit our website at http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have any questions regarding the information provided in or attached to this email, please call (919) 817-4382. Please be aware that information sent via electronic mail is immediately available for release to the public. Therefore, the information contained in and attached to this e-mail is now public information.

Sincerely,

Wanda A. Edwards, BS, BSN, RN

Licensure Consultant

Adult Care Licensure Section

Division of Health Service Regulation

STAR RATING

If the Statement of Deficiencies attached to this email is a result of an annual, follow-up or complaint inspection a star rating certificate and worksheet will be issued within 45 days of the date of this email. If you would like to know more information about the NC Star Rated Certificate Program or view facility ratings, please visit the star rating website at http://www.ncdhhs.gov/dhsr/acls/star/index.html. If you have questions about this facility's star rating or the rating program in general, please send an email with your questions to the star rating customer service email address at DHSR.AdultCare.Star@lists.ncmail.net.

Please note information regarding Customer Service Survey below.

In an ongoing effort to improve the inspection process with the providers we serve, we would like you to complete a Customer Service Survey. The Survey can be accessed at the web site below. Your opinion is important to us, and will assist us in developing new and better ways to do our job.

Please note: Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

Thank you for participating in this confidential survey as we strive to improve the services we provide to licensed health care providers across the state of North Carolina. Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Mark Payne, Director, at 919-855-3750.

Customer Service Survey web site: **http://www2.ncdhhs.gov/dhsr/customerservice.html**

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