Received via email 06/06/22
hrp

PRINTED: 05/09/2022
FORM APPROVED

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
	HAL041033	A. BUILDING: _____ B. WING _____	R 04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up and an annual survey from April 26, 2022 to April 29, 2022.	D 000		
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 Based on interviews and record reviews the facility failed to provide supervision for 1 of 5 sampled residents (#2) who sustained 8 falls in 8 weeks, one of which resulted in an injury. The findings are: Review of the facility's Falls Management policy dated February 2022 revealed: -A fall risk assessment was to be performed upon admission. -Residents who sustained a fall should have a post-fall evaluation completed to consider possible interventions to reduce the potential for future falls and injury. -Communicate new interventions with care staff. -Update the resident's personal service plan (PSP) with appropriate interventions. -Update the Care Assignment sheet. -Have the resident assessed for therapy, as appropriate.	D 270		

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

Kellan Smith | Campus Director | 06/03/2022

Reviewed and acknowledged 06/16/22
hrp

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D 270	Continued From page 1 -Review all falls at stand-up. Review of Resident #2's current FL-2 dated 02/09/22 revealed: -Diagnoses included dementia, chronic kidney disease II, hyperlipidemia, spinal stenosis, and hypertension. -Resident #2 was constantly confused. -Resident #2 was incontinent of bowel and bladder. -Resident #2 required assistance with bathing and dressing. Review of Resident #2's fall risk evaluation form dated 02/28/22 revealed: -Resident #2 was considered a level 3 on the facility's fall risk assessment. -Resident #2 had 2 falls within the past 12 months. -Resident #2 was incontinent and needed assistance with toileting. -Resident #2 had problems with ambulating and/or transferring. -Resident #2 appeared unsteady when ambulating. Review of Resident #2's personal service plan and plan of care dated 02/28/22 revealed: -Resident #2 used oxygen equipment. -Resident #2 took seven or more medications. -Resident #2 took benzodiazepine medications (medications that can contribute to falls in older adults). -Resident #2 was incontinent of bowel and required assistance. -Resident #2 was to be assisted using the bathroom schedule; approximately every 2-4 hours during the day and as needed during the night. -Resident #2 required escort assistance	D 270		

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D 270	Continued From page 2 secondary to memory impairment and physical impairment. -Resident #2 required limited assistance with toileting, ambulation, personal hygiene, and extensive assistance with grooming. -There was an asterisk placed beside the statement to consider the involvement of physical and/or occupational therapy to consult related to strength, gait training, cognition, and adaptive equipment. -Comments were documented as the resident could walk using a walker at this time. She needed standby assistance for ambulation. -There was a hand-written note dated 03/06/22, fall, orientation to new surroundings, and call bell. -There was a hand-written note dated 03/19/22, fall, educated staff to ensure walker in reach before leaving the room. Review of Resident #2's 30-day personal service plan dated 03/29/22 revealed: -Resident #2 used oxygen equipment. -Resident #2 took seven or more medications. -Resident #2 took benzodiazepine medications (medications that can contribute to falls in older adults). -Resident #2 was incontinent of bowel and required assistance. -Resident #2 was to be assisted using the bathroom schedule; approximately every 2-4 hours during the day and as needed during the night. -Resident #2 required escort assistance secondary to memory impairment and physical impairment. -Resident #2 required limited assistance with toileting, ambulation, personal hygiene, and extensive assistance with grooming. -There was an asterisk placed beside the statement to consider the involvement of physical	D 270		

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D 270	Continued From page 3 and/or occupational therapy to consult related to strength, gait training, cognition, and adaptive equipment. -Comments documented were the resident could walk using a walker at this time. She needed standby assistance for ambulation. Resident #2 had three falls since her move-in, a fall on 03/06/22 with no injury, a fall on 03/19/22 with first aid, and a fall on 03/29/22 with an injury and emergency department (ED) visit and treatment. Staff to ensure Resident #2's walker was within reach at all times and oxygen tubing was not tangled. Review of Resident #2's incident and accident reports, progress notes, and post-fall evaluation forms revealed the resident had 8 falls between 02/26/21-04/26/22. a. Review of Resident #2's progress note dated 02/26/22 revealed: -At 2:25pm, Resident #2 was found on the floor a little after breakfast. Resident #2 had no injuries or complaints of pain or discomfort. -At 9:10pm, Resident #2 was reminded to call for assistance when needing help with transferring to prevent a fall. Review of Resident #2's progress notes and post-fall evaluation forms revealed there was no documentation of increased supervision or interventions implemented to prevent Resident #2 from falling. Review of Resident #2's incident and accident reports revealed there was no incident report provided for the fall on 02/26/22. Review of Resident #2's post-fall evaluation completed on 02/26/22 revealed:	D 270		

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D 270	Continued From page 4 -The post-fall evaluation had two parts. -The first part was to be completed by the Health and Wellness Director (HWD) or the first person on the scene. -Part one was completed by a medication aide (MA). -Resident #2 had a fall on 02/26/22 at 9:30am and was found on her back near her bed. -Part two was to be completed by the HWD. -Section A was evaluation, section B was risk factors and section C was interventions put in place to reduce the risk of future falls. -Part two was not completed or signed. Refer to the interview with a medication aide (MA) on 04/28/22 at 7:03am. Refer to the interview with a personal care aide (PCA) on 04/28/22 at 7:23am. Refer to the interview with Resident #2 on 04/28/22 at 7:33am. Refer to the interview with a PCA/MA on 04/28/22 at 10:33am. Refer to the interview with another MA on 04/28/22 at 11:51am. Refer to the interview with the facility's contracted Registered Nurse (RN) on 04/28/22 at 12:26pm. Refer to the interview with the Administrator on 04/28/22 at 1:46pm. Refer to the telephone interview with Resident #2's primary care provider (PCP) on 04/29/22 at 8:36am. Refer to the telephone interview with Resident	D 270		

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D 270	Continued From page 5 #2's family member on 04/29/22 at 10:26am. b. Review of Resident #2's incident and accident report dated 03/06/22 revealed: -Resident #2 had an unwitnessed fall on 03/06/22 at 7:00am. -Resident #2 had no injury noted. Review of Resident #2's post-fall evaluation completed on 03/06/22 revealed: -The post-fall evaluation had two parts. -The first part was to be completed by the Health and Wellness Director (HWD) or the first person on the scene. -Part one was completed by a medication aide (MA). -Resident #2 had a fall on 03/06/22; there was no time documented. -Resident #2 was leaning back on her elbows on the floor. -The resident was walking without her walker. -The form was completed by the HWD. -Part two was to be completed by the HWD. -Section A was evaluation, section B was risk factors and section C was interventions put in place to reduce the risk of future falls. -Part two was signed as completed by the HWD on 03/11/22 . -Section C, service plan interventions to reduce the risk of future falls, was blank. Review of Resident #2's progress notes revealed there was no progress note documented for the fall on 03/06/22. Review of Resident #2's progress note, incident and accident report, and post-fall evaluation form revealed there was no documentation of increased supervision or interventions implemented to prevent Resident #2 from falling.	D 270		

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D 270	Continued From page 6 There was no documentation of increased supervision or interventions implemented to prevent Resident #2 from falling. Refer to the interview with a medication aide (MA) on 04/28/22 at 7:03am. Refer to the interview with a personal care aide (PCA) on 04/28/22 at 7:23am. Refer to the interview with Resident #2 on 04/28/22 at 7:33am. Refer to the interview with a PCA/MA on 04/28/22 at 10:33am. Refer to the interview with another MA on 04/28/22 at 11:51am. Refer to the interview with the facility's contracted Registered Nurse (RN) on 04/28/22 at 12:26pm. Refer to the interview with the Administrator on 04/28/22 at 1:46pm. Refer to the telephone interview with Resident #2's primary care provider (PCP) on 04/29/22 at 8:36am. Refer to the telephone interview with Resident #2's family member on 04/29/22 at 10:26am. c. Review of Resident #2's incident and accident report dated 03/19/22 revealed: -Resident #2 had an unwitnessed fall on 03/19/22 at 1:00pm. -Resident #2 had swelling near her right ear. Review of Resident #2's progress notes revealed	D 270		

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D 270	Continued From page 7 on 03/19/22, Resident #2 had puffiness on the right side of her temple and the power of attorney (POA) declined to send the resident out and only to monitor the resident. Review of Resident #2's post-fall evaluation completed on 03/19/22 revealed: -The post-fall evaluation had two parts. -The first part was to be completed by the Health and Wellness Director (HWD) or the first person on the scene. -Part one was completed by a medication aide (MA). -Resident #2 had a fall on 03/19/22; there was no time documented. -Resident #2 was found sitting on the floor. -Resident #2 complained of pain on the right side of her temple. -The resident reported she was walking back to her chair when the fall occurred. -The form was completed by the HWD. -Part two was to be completed by the HWD. -Section A was evaluation, section B was risk factors and section C was interventions put in place to reduce the risk of future falls. -Section B was documented as environmental factors contributed to the fall. -Part two was signed as completed by the HWD on 03/21/22 . -Section C, service plan interventions to reduce the risk of future falls, was blank. Review of Resident #2's incident and accident report, post-fall evaluation form, and progress notes revealed there was no documentation of increased supervision or interventions implemented to prevent Resident #2 from falling. Refer to the interview with a medication aide (MA) on 04/28/22 at 7:03am.	D 270		

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D 270	Continued From page 8 Refer to the interview with a personal care aide (PCA) on 04/28/22 at 7:23am. Refer to the interview with Resident #2 on 04/28/22 at 7:33am. Refer to the interview with a (PCA)/MA on 04/28/22 at 10:33am. Refer to the interview with another MA on 04/28/22 at 11:51am. Refer to the interview with the facility's contracted Registered Nurse (RN) on 04/28/22 at 12:26pm. Refer to the interview with the Administrator on 04/28/22 at 1:46pm. Refer to the telephone interview with Resident #2's primary care provider (PCP) on 04/29/22 at 8:36am. Refer to the telephone interview with Resident #2's family member on 04/29/22 at 10:26am. d. Review of Resident #2's post-fall evaluation completed on 03/25/22 revealed: -The post-fall evaluation had two parts. -The first part was to be completed by the Health and Wellness Director (HWD) or the first person on the scene. -Part one was completed by a medication aide (MA). -Resident #2 had a fall on 03/25/22 at 5:45 (there was no documentation of am or pm). -Resident #2 was found sitting on the floor in her bathroom. -Resident #2 denied pain. -The resident reported she was going to the	D 270		

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D 270	Continued From page 9 bathroom when the fall occurred. -The form was completed by a MA. -Part two was to be completed by the HWD. -Section A was evaluation, section B was risk factors and section C was interventions put in place to reduce the risk of future falls. -Part two was not completed or signed. Review of Resident #2's incident and accident reports revealed there was no incident report provided for the fall on 03/25/22. Review of Resident #2's progress notes revealed there was no progress report provided for the fall on 03/25/22. Review of Resident #2's incident and accident reports, progress notes, and post fall evaluation form revealed there was no documentation of increased supervision or interventions implemented to prevent Resident #2 from falling. Refer to the interview with a medication aide (MA) on 04/28/22 at 7:03am. Refer to the interview with a personal care aide (PCA) on 04/28/22 at 7:23am. Refer to the interview with Resident #2 on 04/28/22 at 7:33am. Refer to the interview with a PCA/MA on 04/28/22 at 10:33am. Refer to the interview with another MA on 04/28/22 at 11:51am. Refer to the interview with the facility's contracted Registered Nurse (RN) on 04/28/22 at 12:26pm.	D 270		

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D 270	Continued From page 10 Refer to the interview with the Administrator on 04/28/22 at 1:46pm. Refer to the telephone interview with Resident #2's primary care provider (PCP) on 04/29/22 at 8:36am. Refer to the telephone interview with Resident #2's family member on 04/29/22 at 10:26am. e. Review of Resident #2's incident and accident report dated 03/29/22 revealed: -Resident #2 had an unwitnessed fall on 03/29/22 at 12:30am. -Resident #2 fell and caused an abrasion to her right upper eyebrow, emergency medical services (EMS) were called and the resident was sent out for an evaluation. The resident was sent back and was resting comfortably. Review of Resident #2's progress notes revealed on 03/29/22, Resident #2 was observed with a cut on the right side of her temple and a gash on the right side of her head. Review of Resident #2's hospital discharge summary dated 03/29/22 revealed: -Resident #2 was seen secondary to a fall. -The history was obtained from Resident #2 and EMS report. -Resident #2 sustained injuries secondary to a fall that occurred when the resident tripped over oxygen tubing while ambulating to the bathroom. -Resident #2 hit the side of her head. -Resident #2 did not know if she had lost consciousness or not. -Resident #2 complained of left shoulder pain to the EMS staff, but denied any pain at the time of the assessment. -Resident #2 had a 2-centimeter laceration to her	D 270		

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D 270	Continued From page 11 right scalp. -Resident #2 had a CT scan of her spine and head, both were negative. -Resident #2 had a chest x-ray, which was negative for acute traumatic injury. -Scalp laceration was repaired with staples. -Resident #2 was returned to the facility with primary care provider follow-up. Review of Resident #2's post-fall reports provided by the facility revealed there was no post-fall report provided for the fall on 03/29/22. Review of Resident #2's incident and accident reports and progress notes revealed there was no documentation of increased supervision or interventions implemented to prevent Resident #2 from falling. Interview with a medication aide (MA) on 04/28/22 at 7:03am revealed: -She reminded Resident #2 to use her call bell. -She thought Resident #2 tripped over her oxygen tubing. -She did not recall if she had documented or told anyone about the oxygen tubing. Interview with a PCA on 04/28/22 at 7:23am revealed she thought Resident #2 may have fallen over her oxygen tubing the time she observed the resident after a fall. Refer to the interview with a MA on 04/28/22 at 7:03am. Refer to the interview with a personal care aide (PCA) on 04/28/22 at 7:23am. Refer to the interview with Resident #2 on 04/28/22 at 7:33am.	D 270		

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D 270	Continued From page 12 Refer to the interview with a PCA/MA on 04/28/22 at 10:33am. Refer to the interview with another MA on 04/28/22 at 11:51am. Refer to the interview with the facility's contracted Registered Nurse (RN) on 04/28/22 at 12:26pm. Refer to the interview with the Administrator on 04/28/22 at 1:46pm. Refer to the telephone interview with Resident #2's primary care provider (PCP) on 04/29/22 at 8:36am. Refer to the telephone interview with Resident #2's family member on 04/29/22 at 10:26am. f. Review of Resident #2's progress notes revealed on 04/09/22 at 6:55pm, Resident #2 was found on the floor. The resident's walker was lying on its side beside her. The resident said she had gotten up to go to the bathroom. Resident #2's call bell was still attached to her recliner and was not used by the resident to call for assistance. The resident was shown again how to use the call bell to call for assistance. Review of Resident #2's incident and accident reports revealed there was no incident and accident report provided for the fall on 04/09/22. Review of Resident #2's post fall reports revealed there was no post-fall report provided for the fall on 04/09/22. Review of Resident #2's progress notes revealed there was no documentation of increased	D 270		

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D 270	Continued From page 13 supervision or interventions implemented to prevent Resident #2 from falling. Refer to the interview with a medication aide (MA) on 04/28/22 at 7:03am. Refer to the interview with a personal care aide (PCA) on 04/28/22 at 7:23am. Refer to the interview with Resident #2 on 04/28/22 at 7:33am. Refer to the interview with a PCA/MA on 04/28/22 at 10:33am. Refer to the interview with another MA on 04/28/22 at 11:51am. Refer to the interview with the facility's contracted Registered Nurse (RN) on 04/28/22 at 12:26pm. Refer to the interview with the Administrator on 04/28/22 at 1:46pm. Refer to the telephone interview with Resident #2's primary care provider (PCP) on 04/29/22 at 8:36am. Refer to the telephone interview with Resident #2's family member on 04/29/22 at 10:26am. g. Review of Resident #2's post-fall evaluation completed on 04/14/22 revealed: -The post-fall evaluation had two parts. -The first part was to be completed by the Health and Wellness Director (HWD) or the first person on the scene. -Part one was completed by a medication aide (MA). -Resident #2 had a fall on 04/14/22 at 1:00 (there	D 270		

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D 270	Continued From page 14 was no documentation of am or pm). -Resident #2 was found sitting on the floor in her room. -Resident #2 denied pain. -The resident reported she was going toward the door to her room when she lost her balance and fell. -The form was completed by a MA. -Part two was to be completed by the HWD. -Section A was evaluation, section B was risk factors and section C was interventions put in place to reduce the risk of future falls. -Part two was not completed or signed. Review of Resident #2's incident and accident reports revealed there was no incident and accident report provided for the fall on 04/14/22. Review of Resident #2's progress notes revealed there was no progress note for the fall on 04/14/22. Review of Resident #2's post-fall evaluation revealed there was no documentation of increased supervision or interventions implemented to prevent Resident #2 from falling. Refer to the interview with a medication aide (MA) on 04/28/22 at 7:03am. Refer to the interview with a personal care aide (PCA) on 04/28/22 at 7:23am. Refer to the interview with Resident #2 on 04/28/22 at 7:33am. Refer to the interview with a PCA/MA on 04/28/22 at 10:33am. Refer to the interview with another MA on	D 270		

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D 270	Continued From page 15 04/28/22 at 11:51am. Refer to the interview with the facility's contracted Registered Nurse (RN) on 04/28/22 at 12:26pm. Refer to the interview with the Administrator on 04/28/22 at 1:46pm. Refer to the telephone interview with Resident #2's primary care provider (PCP) on 04/29/22 at 8:36am. Refer to the telephone interview with Resident #2's family member on 04/29/22 at 10:26am. h. Review of Resident #2's post-fall evaluation completed on 04/24/22 revealed: -The post-fall evaluation had two parts. -The first part was to be completed by the Health and Wellness Director (HWD) or the first person on the scene. -Part one was completed but was not signed to identify who completed the report. -Resident #2 had a fall on 04/24/22 at 8:00pm in the hallway. -Resident #2 denied pain. -The resident reported she was tired of staying in her room. -Resident #2 was found walking unassisted on three occasions during the shift and did not call for assistance. -Part two was to be completed by the HWD. -Section A was evaluation, section B was risk factors and section C was interventions put in place to reduce the risk of future falls. -Part two was not completed or signed. Review of Resident #2's incident and accident reports revealed there was no incident and accident report provided for the fall on 04/24/22.	D 270		

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D 270	Continued From page 16 Review of Resident #2's progress notes revealed there was no progress note for the fall on 04/24/22. Review of Resident #2's post-fall evaluation revealed there was no documentation of increased supervision or interventions implemented to prevent Resident #2 from falling. Refer to the interview with a medication aide (MA) on 04/28/22 at 7:03am. Refer to the interview with a personal care aide (PCA) on 04/28/22 at 7:23am. Refer to the interview with Resident #2 on 04/28/22 at 7:33am. Refer to the interview with a PCA/MA on 04/28/22 at 10:33am. Refer to the interview with another MA on 04/28/22 at 11:51am. Refer to the interview with the facility's contracted Registered Nurse (RN) on 04/28/22 at 12:26pm. Refer to the interview with the Administrator on 04/28/22 at 1:46pm. Refer to the telephone interview with Resident #2's primary care provider (PCP) on 04/29/22 at 8:36am. Refer to the telephone interview with Resident #2's family member on 04/29/22 at 10:26am. Interview with a medication aide (MA) on 04/28/22 at 7:03am revealed:	D 270		

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D 270	Continued From page 17 -Resident #2 "kept getting up the other day without ringing her call bell." -She did not think Resident #2's memory was "good enough" to remember to use her call bell. -No one had told her to do anything different with Resident #2 after her falls. -She took it upon herself to check on Resident #2 more often. -The personal care aides (PCA) checked on residents every 2-hours. -The minute she walked in the door she made rounds and checked on her residents. -When she made rounds, she did not just look in on Resident #2, she would ask her what she might need. -Resident #2 was "such a fall risk." -Resident #2 could benefit from physical therapy. -She thought Resident #2 would benefit from being around others. Interview with a PCA on 04/28/22 at 7:23am revealed: -She checked on Resident #2 every 2-hours. -She had found Resident #2 after a fall (she did not recall the date). -She did not know if Resident #2 had other falls before that fall. -No one told her to do anything different with Resident #2's care after the fall. -She kept an eye on Resident #2, usually more than every 2-hours to make sure the resident was okay. -No one had told her to check on Resident #2 more often, she just did it. -The only thing she could think of that she had done to prevent falls was to try to make sure Resident #2 had shoes on. -Resident #2 did not cut her call bell on to ask for assistance, "even when it was within reach." -She thought Resident #2's memory was good	D 270		

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D 270	Continued From page 18 enough to remember to use her call light. Interview with Resident #2 on 04/28/22 at 7:33am revealed: -She has had falls. -She did not recall details of the falls but thought it was "just from being weak." -No one had talked to her about physical therapy (PT). -She did not need assistance with going to the bathroom, she could do it herself. -No one had told her not to get up without assistance. -If someone had told her not to get up without assistance, she would not. Interview with a PCA/MA on 04/28/22 at 11:33am revealed: -Residents were supposed to be checked on every 2-hours but it depended on the resident. -Resident #2 liked to get up so she needed to be checked on every 30-minutes. -When Resident #2 was admitted the staff was told the resident was a fall risk and to keep "more eyes on her." -No one told her to do 30-minute checks on Resident #2, she just "knew her "so she checked on her every 30-minutes. -Resident #2 had a fall while she was working, but she did not recall when. -Resident #2 had a "bad fall" since then too. -Resident #2 did not walk much, but if she saw her up she would go to her because she might stumble. -Things that might contribute to Resident #2's falls might be the resident's oxygen tubing was really long and she did not like to wear shoes. Interview with another MA on 04/28/22 at 11:51am revealed:	D 270		

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D 270	Continued From page 19 -She tried to assist Resident #2 as often as she could because the resident had fallen. -If she saw Resident #2 walking without assistance, she would help her so she would not fall. -No one had told her to do anything different for Resident #2 after her falls. -She tried to check on the residents every hour. -She was not aware of anything that was done for residents who were at risk for falls. -She did not know if the facility had a fall risk policy. -Staff did not document 2-hour checks. -Staff did not always do their rounds on the residents like they were supposed to. -She had not told anyone the staff did not do rounds on the residents because she knew nothing would be done. Interview with the facility's contracted Registered Nurse (RN) on 04/28/22 at 12:26pm revealed: -She had been working at the facility for about a month to assist with nursing needs. -She had worked at this facility and was familiar with the processes related to falls. -Systems put in place after a resident had a fall depended on the resident and what occurred. -She expected staff to put a plan in place and make sure all staff was aware of the plan to try to prevent another fall. -She would have recommended a PT evaluation for Resident #2 had she known the resident was falling. -A fall risk assessment was completed upon admission and if there was a change in condition. -Every fall was to be addressed immediately to discuss why the fall occurred and what could be done to prevent falls. -The facility's nurse was responsible for looking at the fall report monthly to identify trends.	D 270		

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D 270	Continued From page 20 -A post-fall risk evaluation should be completed after every fall. -Any recommendations to prevent falls should be discussed in stand-up meetings. -These recommendations were handwritten on the personal service plan. -Recommendations depended on the resident, being creative, and figuring out what would work. -She expected recommendations to be communicated to all staff. -More frequent checks were a standard intervention, at least every 1-2 hours or more often as needed. -Resident checks were not documented, it was just understood the checks were to be done. -Therapy would be initiated after 1-2 falls if the falls were from instability. Interview with the Administrator on 04/28/22 at 1:46pm revealed: -Staff should be checking on residents every 2-4 hours. -If a resident had a history of falls, he would expect staff to check on the resident more often. -He expected staff to investigate why a resident fell and put interventions in place to try to prevent falls. -An example would be if a resident had a fall while trying to go to the bathroom, the resident would be put on a toileting schedule. -Resident #2 would not be able to remember to use her call bell to ask for assistance. -He would have expected a referral to be made to PT/Occupational Therapy (OT) for Resident #2. -PT/OT would be able to assist with ideas on how to reduce falls. -He was concerned there was a lack of follow-through. Telephone interview with Resident #2's primary	D 270		

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D 270	Continued From page 21 care provider (PCP) on 04/29/22 at 8:36am revealed: -She saw Resident #2 for the first time in March 2022. -She did not have any notifications Resident #2 had any falls in March 2022 or April 2022. -She saw Resident #2, yesterday, on 04/28/22, and referred Resident #2 to physical therapy (PT). -She usually referred her patients for physical therapy after one fall. -She usually would see a patient for a post-fall evaluation. -Resident #2 would not be able to remember to use her call bell. -She would have initiated PT sooner had she known Resident #2 was having falls. -If Resident #2 had a fall she was at risk of hitting her head, having a brain bleed, or breaking a bone. Telephone interview with Resident #2's family member on 04/29/22 at 10:26am revealed: -He was aware Resident #2 had been falling, "sometimes as much as once a week." -Staff told Resident #2 not to get up by herself, but the resident would forget. -Resident #2 had not had PT since she moved to the special care unit. -He thought therapy would be great for Resident #2. The facility failed to provide adequate supervision for 1 of 5 sampled residents (#2) who had 8 falls in 8 weeks with no known interventions implemented to prevent falls which resulted in Resident #2 sustaining a laceration after a fall that required an ED visit and staples to repair the laceration. This failure was detrimental to the health, safety and welfare of residents and	D 270		

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D 270	Continued From page 22 constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 04/28/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 13, 2022.	D 270		
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 observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 2 of 5 sampled residents (#1, #2) as evidenced by the failure to have staples removed from a scalp laceration (#2); and a referral for a resident with orders for physical therapy and Home Health skilled nursing and to apply ice to a surgical site to reduce swelling (#1). The findings are: 1. Review of Resident #2's current FL-2 dated 02/09/22 revealed diagnoses included dementia, chronic kidney disease II, hyperlipidemia, spinal stenosis, and hypertension. Review of Resident #2's emergency department (ED) discharge summary dated 03/29/22 revealed: -Resident #2 was seen in the ED secondary to a	D 273		

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D 273	Continued From page 23 fall and subsequent laceration of her scalp. -Resident #2 had a 2-centimeter laceration and 2 staples were used to close the laceration. -There was an order to have Resident #2 see her primary care provider (PCP) in one week, around 04/02/22, to have sutures removed. Observation of Resident #2's scalp on 04/26/22 at 10:15am revealed 2 staples on the right side of her scalp. Interview with Resident #2 on 04/26/22 at 10:15am revealed: -She did not know she had staples. -She did not know when she last saw her PCP. Interview with a medication aide (MA)/personal care aide (PCA) on 04/27/22 at 10:11am revealed: -Resident #2 refused showers but was given a "wash up." -She combed Resident #2's hair when she worked with her as a PCA. -She had worked with Resident #2 as a PCA over the past month. -She did not know Resident #2 had staples in her scalp. -Usually, the MA would tell her something like that, but they did not tell her Resident #2 had staples. Telephone interview with Resident #2's PCP's medical assistant on 04/26/22 at 10:28am revealed: -Resident #2 was seen by the PCP on 03/15/22. -Resident #2 was scheduled to be seen by the PCP on 04/27/22 for a routine monthly visit. -There was no documented information in Resident #2's record related to a fall. -The only note documented on Resident #2 was	D 273		

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D 273	Continued From page 24 dated 04/02/22 when the resident refused to take a medication. Telephone interview with Resident #2's PCP on 04/26/22 at 2:51pm revealed: -She did not know Resident #2 had a fall and had staples secondary to a laceration. -She was concerned Resident #2's staples had not been removed because the skin could grow over the staples, the staples could become embedded and difficult to removed and it increased the risk of infection. -She would have expected to be notified of Resident #2's staples after the resident returned from the ED. Interview with the facility's Registered Nurse (RN) on 04/26/22 at 2:56pm revealed: -She had been working at the facility since late March 2022. -The Health and Wellness Director (HWD) was the facility's nurse. -She was not aware Resident #2 had a fall on 03/29/22. -The MA should have made a follow-up appointment for Resident #2 to have the staples removed. -If Resident #2's family took her to appointments, the family should have been notified. -If the facility provided transportation, the MA should have notified the transportation coordinator, who would have scheduled a follow-up appointment and provided transportation. -She was concerned Resident #2's staples had not been removed because it put the resident at risk for infection. Review of the new order tracking book on 04/26/22 at 3:14pm revealed there was no	D 273		

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D 273	Continued From page 25 information related to Resident #2's staples. Interview with the transportation coordinator on 04/26/22 at 3:22pm revealed: -She had not transported Resident #2 to any appointments. -Resident #2's family took the resident to any appointments outside of the facility. Telephone interview with a MA on 04/26/22 at 3:28pm revealed: -She had received Resident #2's ED discharge papers when the resident returned to the facility on 03/9/22. -She notified the facility's RN Resident #2 had a fall. -Resident #2 returned to the facility "right before shift change." -She notified the next shift Resident #2 had gone to the ED, had come back, and placed the resident's discharge papers on the Supervisor/MA's desk. -She knew Resident #2 had staples, how long the staples were to be in and when the staples were supposed to be removed. -She did not make a follow-up appointment because Resident #2 returned before 7:00am. -She thought the nurse would have been responsible for making a follow-up appointment for Resident #2. -She did not know Resident #2's staples had been removed. Interview with the facility's Supervisor/MA on 04/26/22 at 3:34pm revealed: -She had not seen Resident #2's ED discharge papers on her desk. -If Resident #2's discharge papers had been on her desk she would have given the papers to the facility's RN and made a follow-up appointment to	D 273		

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D 273	Continued From page 26 have the staples removed. -The MA should have let someone know Resident #2 had staples to be removed. -Even third shift MA's knew what to do when a resident had an order. -They used an electronic device to communicate with the PCP and the PCP should have been notified of the order. Telephone interview with another MA on 04/26/22 at 3:54pm revealed: -She recalled the third shift MA telling her Resident #2 had staples, but no one told her she needed to do anything. -She did not recall seeing Resident #2's ED discharge papers. -She would have called Resident #2's PCP had she seen the ED discharge papers. -New orders were to be put into the facility's electronic medial record system so the order would "pop up" on the electronic medication administration record (eMAR). -She did not know if staple removal should have been added into the eMAR but had she known she would have asked Supervisor/MA or the RN where to put the order. Interview with the Administrator on 04/26/22 at 4:21pm revealed: -Resident #2's discharge papers should have been given to the RN. -The RN would have been responsible for putting Resident #2 on the PCP's schedule to be seen. -He was concerned there was a lack of follow-up, training on the process for using the new order tracking form and things were not getting done. Telephone interview with Resident #2's family member on 04/29/22 at 10:26am revealed: -They were aware Resident #2 had a fall and she	D 273		

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D 273	Continued From page 27 had staples to close the laceration to her scalp. -They provided transportation for Resident #2. -No one had requested an appointment for Resident #2. 2. Review of Resident #1's current FL2 dated 02/07/22 revealed: -Diagnoses included confusion, recurrent right inguinal hernia, and cerebrovascular accident. -The resident was intermittently disoriented. Review of Resident #1's addendum to FL2 dated 02/18/22 revealed abnormal neurological confusion was documented. Review of Resident #1's Resident Register revealed an admission date of 02/27/22. a. Review of Resident #1's physician's order from Resident #1's primary care provider (PCP) dated 03/08/22 revealed an order to apply ice to the right groin area for a minimum of 5 weeks. Review of Resident #1's physician's order dated 03/10/22 from Resident #1 surgeon revealed an order for apply ice to groin as needed for a maximum of 15 minutes at a time. Review of Resident #1's physician's orders, and progress notes revealed there was no documentation for subsequent orders related to apply ice to the right groin area. Review of Resident #1's March 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry dated 03/11/22 for apply ice to the groin area for a maximum of 15 minutes. Apply 15 minutes as needed for swelling, with as needed (prn) for the time of administration	D 273		

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D 273	Continued From page 28 indicated on the eMAR. The entry had a date of 03/22/22 for the discontinued date for the order. -There was no documentation for the application of ice to the groin areas from 03/11/22 to 03/22/22. -There was a second entry dated 03/11/22 for apply ice to the groin area for a maximum of 15 minutes, after meals and at bedtime for swelling, scheduled at 6:30am, 11:00am, 4:00pm, and 7:30pm. The order was discontinued on 03/22/22. -There was documentation of application of ice to the groin area on 03/22/21 at 6:30am, 11:00am, and 4:00pm. -There was a third entry dated 03/22/22 for apply ice to the groin area for a maximum of 15 minutes, four times a day for swelling, scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -From 03/23/22 at 8:00am to 03/31/22 at 8:00pm, apply ice to the groin area for a maximum of 15 minutes was documented for 30 of 36 opportunities and refused 6 of 36 opportunities. Review of Resident #1's April 2022 eMAR revealed: -There was an entry dated 03/22/22 for apply ice to the groin area for a maximum of 15 minutes, four times a day for swelling, scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -From 04/01/22 at 8:00am to 04/25/22 at 8:00pm, apply ice to the groin area for a maximum of 15 minutes was documented for 93 of 100 opportunities and refused 7 of 100 opportunities. Observation of Resident #1 on 04/28/22 at 4:00pm revealed: -Resident #1 was ambulating independently through out the sitting are at the back of the special care unit.	D 273		

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D 273	Continued From page 29 -Resident #1 was headed into another resident's room and was redirected back to the sitting area. -Resident #1 did not appear to be in pain or having difficulty ambulating. Interview the facility's contracted Registered Nurse (RN) on 04/26/22 at 11:32am revealed: -She had been working at the facility since late March 2022. -The Health and Wellness Director (HWD) was the facility's nurse. -She discovered Resident #1 was not receiving icing to the groin area on 03/23/22 after discussing Resident #1's care with the HWD. -She found out on 02/23/22 that the HWD called Resident #1's family to bring an ice bag or ice pack to be used by the facility for icing the groin area. -She discussed with the facility's medication aides (MAs) to make sure Resident #1's order for icing the groin area was done and documented. -She did not know why the facility had not started routinely icing Resident #1's groin area as ordered on 03/08/22 and 03/10/22. -The HWD would have been responsible to notify the primary care provider (PCP) if a treatment was not done as ordered. -She did not notify Resident #1's PCP or surgeon that Resident #1 was not receiving routine icing to the groin area from 03/08/22 to 03/23/22. Review of Resident #1's progress notes revealed, on 03/23/22 at 11:45am, the RN documented "[Groin] remains swollen but per HWD it has improved. Area has been iced 2 times today as well." Telephone interview with Resident #1's PCP on 04/26/22 at 2:59pm revealed: -Resident #1's order to apply ice to the groin area	D 273		

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D 273	Continued From page 30 was sent to the facility after she was contacted by a family member of Resident #1 on 03/08/22, regarding needing an order sent to the facility for icing Resident #1's groin. -Applying ice to the groin area to helped reduce swelling was a routine procedure post hernia surgery and she ordered the treatment for the resident. -There was no documentation the facility had contacted the PCP for the order to ice the groin area prior to the family's contact on 03/08/22. Interview with a personal care aide (PCA)/medication aide (MA) on 04/28/22 at 11:05pm revealed: -Resident #1 was assisted with toileting every 2 hours. -She had noticed Resident #1's groin was red and swollen and told the previous HWD. -She was not given any directions at that time to do anything different, but after she returned from being off (the end of March 2022) the order to apply ice popped up on Resident #2's eMAR. -When she asked the previous HWD about the order to ice Resident #1's scrotum, she was told the order had been missed. -She "felt bad" for Resident #2 that the order had been missed. Interview with the Administrator on 04/26/22 at 4:17pm revealed: -The HWD was the facility's nurse. -The HWD was responsible to enter orders for medications and/or treatments or to check orders entered by the facility's MAs. -There was a system in place to enter all new orders, including treatments, onto a new order tracking form for documentation of entering orders in the eMAR system; then a second staff verified the accuracy and completion of the order	D 273		

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D 273	Continued From page 31 entry with documentation. -The system was to be used by all staff including the HWD with a staff checking the HWD's entries. -There was no documentation the HWD followed the system for orders she entered. -He was concerned there was a lack of follow-up, training on the process for using the new order tracking form and things were not getting done. -The PCP should have been notified regarding not starting the order for icing Resident #1's groin from 03/08/22 to 03/23/22. Telephone interview with Resident #1's family member on 04/28/22 at 9:00am revealed: -Resident #1 had been cared for in a family member's home for 2 to 3 weeks post surgery to repair a hernia on 02/11/22. -The family members had applied cold compresses to the genital area 4 times a day, per post surgery instructions oral instructions from the surgery discharge. -The swelling in the genital area was reducing and controlled. -The facility was made aware of Resident #1's status related to post-surgical care needs to apply cold compresses (ice) to the groin area 4 times a day when the family member met the Administrator, Executive Director and the HWD of the facility prior to admission in mid February 2022. -The facility Administrator and Executive Director assured the family that Resident #1's health care needs could be met by the facility. -Resident #1 was assessed prior to admission and based on screenings was best suited for care in the Special Care Unit (SCU). -Resident #1 came to the facility on 02/27/22. -The family was advised that a one week adjustment period without family member visits was best for the new residents, allowing time for	D 273		

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D 273	Continued From page 32 adjustment and orientation to the new surroundings. -When the family member saw Resident #1 after one a week (give or take a day), Resident #1 had swelling returned to the groin area. -The family member questioned the facility medication aides (MA) and was told there was no order for apply cold therapy (or ice) to Resident #1's groin area and without an order the staff could not apply cold compresses. -The family member spoke with the facilty's nurse (around 03/06/22) and was told that she would reach out to the resident's primary care provider (PCP) that provided the admission information regarding an order to apply ice or cold compression to the groin area. -On 03/10/22, Resident #1 still did not have cold compresses or ice therapy to the groin area when the family visited, so a family member contacted Resident #1 PCP for an order to apply ice or cold compress therapy to the groin area. -Resident #1 continued to have swelling in the groin area noted when the family visited. -The family was advised on 03/22/22 or 03/23/22 that the facility needed some type of ice bag or cold wrap to complete the order and one was supplied by the family immediately. -Resident #1's swelling had improved since 03/23/22 when the facility started to ice the groin area. -The swelling was not completely gone. -The family member felt that Resident #1's swelling was prolonged by the facility's not starting the icing on 03/10/22 as ordered. -The family member canceled a follow-up appointment in April 2022 scheduled with the surgeon, and rescheduled in May 2022 in order to allow the ice therapy to reduce swelling prior to the visit.	D 273		

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D 273	Continued From page 33 Interview with a personal care aide/MA on 04/28/22 at 11:05pm revealed: -Resident #1 was assisted with toileting every 2 hours. -She had noticed Resident #1's groin was red and swollen and told the previous Registered Nurse (RN). -She was not given any directions at that time to do anything different, but after she returned from being off (the end of March 2022) the order to apply ice popped up on Resident #2's eMAR. -When she asked the previous RN about the order, she was told the order had been missed. -She felt bad for Resident #2 that the order had been missed. Telephone interview with the previous HWD on 04/28/22 at 1:28pm revealed: -She was no longer working at the facility. -Resident #1 did not have an order to apply ice to the groin area when he was admitted to the facility. -The family made her aware that the surgeon had recommended applying ice to the groin several times daily after the surgery when they visited around 03/05/22. -The HWD called Resident #1's PCP 2 or 3 times within the next week for an order to apply ice to Resident #1's groin (no documentation was available) and was told the PCP would send an order but no order was sent. -When the facility received the order to apply ice to Resident #1's groin, it was entered by a MA as needed with no scheduled time. -The order was scheduled for 4 times a day and subsequently changed to before meals per the family request. -She did not notify the PCP that the order for icing Resident #1's groin dated 03/10/22 was finally scheduled for 4 times a day and started routinely	D 273		

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D 273	Continued From page 34 on 03/23/22. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. b. Review of Resident #1's addendum to FL2 dated 02/18/22 revealed an order for Home Health evaluation and treatment for skilled nursing subsequent to a face to face encounter dated 01/05/22. Review of Resident #1's physician's orders and progress notes revealed: -There was no documentation for a referral to Home Health skilled nursing services completed as ordered. -There was no documentation Resident #1's primary care provider (PCP) was notified regarding not arranging a Home Health skilled nursing evaluation and treatment. Interview the facility's contracted Register Nurse (RN) on 04/26/22 at 11:32am revealed: -She had been working at the facility since late March 2022. -The Health and Wellness Director (HWD) was the facility's nurse. -She did not know why there was no documentation for completion of a Home Health skilled nursing evaluation or treatment as ordered on the FL2 addendum dated 02/18/22. -The HWD would have been responsible to ensure the Home Health skilled nursing evaluation was completed or to notify the PCP if a treatment was not done as ordered. Telephone interview with the corporate Home Health Coordinator (HHC) on 04/26/22 at 1:58pm revealed:	D 273		

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D 273	Continued From page 35 -The HHC was responsible to coordinate home health services for residents using the residents' resources for payment and various home heath agencies. -Normally, the HWD at the facility was responsible to contact the HHC when an order for skilled nursing evaluation was received. -The HHC would obtain the required documentation for the resident, contact the Home Health agency to schedule the evaluation visit. -There was no documentation that the order for Home Health skilled nursing services on the FL2 addendum dated 02/18/22 for Resident #1 was sent to the HHC. Telephone interview with Resident #1's primary care provider (PCP) on 04/26/22 at 2:59pm revealed: -Resident #1 had a surgical repair of a right side hernia done around 11/22/21 that failed. -She saw Resident #1 on 01/05/22 per the family's request prior to the next scheduled hernia repair surgery. -Resident #1's order for Home Health skilled nursing evaluation and treatment was subsequent to a face to face visit with Resident #1 on 01/05/22. -She thought the resident would benefit from Home Health skilled nursing monitoring the resident after the second surgery and ordered the evaluation on the FL2 addendum dated 02/18/22. -There was no documentation for contact from the facility regarding the Home Health skilled nursing evaluation ordered on 02/18/22 was not done after admission on 02/27/22. Interview with the Administrator on 04/26/22 at 4:17pm revealed: -The HWD was responsible to enter orders for treatments and to ensure Home Health skilled	D 273		

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D 273	Continued From page 36 nursing evaluations were completed. -There was a system in place to enter all new orders, including treatments, onto a new order tracking form for documentation of entering orders in the eMAR system; then a second staff member verified the accuracy and completion of the order enter with documentation. -The system was to be used by all staff including the HWD with a staff member checking the HWD's entries. -There was no documentation the HWD followed the system for orders she entered. -He was concerned there was a lack of follow-up, training on the process for using the new order tracking form and things were not getting done. -The PCP should have been notified regarding Resident #1's order for a Home Health skilled nursing evaluation dated 02/18/22 not referred to a Home Health agency. Telephone interview with the previous HWD on 04/28/22 at 1:28pm revealed: -She was no longer working at the facility. -The HWD was responsible to ensure any orders appearing on the FL2 addendum were completed. -The corporate Home Health Coordinator (HHC) should be contacted to process an order for skilled nursing evaluation and treatment. -If Resident #1 had an order for Home Health skilled nursing evaluation and treatment not processed, she must have overlooked notifying the HHC or notifying the PCP for the order not completed. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. c. Review of Resident #1's addendum to FL2	D 273		

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D 273	Continued From page 37 dated 02/18/22 revealed an order for evaluation and treatment from Physical Therapy (PT) subsequent to a face to face encounter dated 01/05/22. Interview the facility's contracted Register Nurse (RN) on 04/26/22 at 11:32am revealed: -She had been working at the facility since late March 2022. -The Health and Wellness Director (HWD) was the facility's nurse. -She did not know why there was no documentation for completion of a PT evaluation or treatment as ordered on the FL2 addendum dated 02/18/22. -The HWD would have been responsible to ensure the physical therapy evaluation was completed or to notify the PCP if a treatment was not done as ordered. Telephone interview with the corporate Home Health Coordinator (HHC) on 04/26/22 at 1:58pm revealed: -Routinely, the HWD was responsible to contact the HHC when an order for physical therapy was received. -The HHC would obtain the required documentation for the resident, contact the Home Health agency to schedule the evaluation visit. -There was no documentation that the order for PT on the FL2 addendum dated 02/18/22 for Resident #1 was sent to the HHC. Telephone interview with Resident #1's PCP on 04/26/22 at 2:59pm revealed: -Resident #1 had a surgical repair of a right side hernia done around 11/22/21 that failed. -She saw Resident #1 on 01/05/22 per the family's request prior to the next scheduled hernia repair surgery.	D 273		

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D 273	Continued From page 38 -Resident #1 appeared to be weak and having trouble ambulating when she saw the resident in the office. -Resident #1's order for PT evaluation and treatment was subsequent to a face to face visit with Resident #1 on 01/05/22. -She thought the resident would benefit from PT to strengthen and assist with ambulating and ordered the evaluation on the FL2 addendum dated 02/18/22. -There was no documentation for contact from the facility regarding a PT evaluation not done after admission on 02/27/22. Interview with the Administrator on 04/26/22 at 4:17pm revealed: -The HWD was responsible to enter orders for treatments and to ensure PT evaluations were completed. -There was a system in place to enter all new orders, including treatments, onto a new order tracking form for documentation of entering orders in the eMAR system. -The system was to be used by all staff including the HWD with a staff member checking the HWD's entries. -There was no documentation the HWD followed the system for ordering PT evaluation for Resident #1. -He was concerned there was a lack of follow-up, training on the process for using the new order tracking form and things were not getting done. -The PCP should have been notified regarding Resident #1's order for a PT evaluation dated 02/18/22 not referred to a Home Health agency. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	D 273		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 39 The facility failed to ensure referral and follow-up for a resident (#2) who had staples that were not removed for three weeks after the date of recommended removal which could result in skin growing over the staples and infection; and a resident (#1) who had surgery with an order for ice be applied to his groin to reduce swelling which was not started in a timely manner resulting in prolonged swelling and redness; and orders upon admission for referrals to Home Health skilled nursing and physical therapy were not completed. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/26/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 13, 2022.	D 273		
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 observations, interviews and record reviews, the facility failed to ensure orders were implemented and documented for 2 of 5 sampled	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING _____ B. WING _____	R 04/29/2022

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D 276	Continued From page 40 residents (#1, #3) related to blood pressure (BP) checks (#1) and obtaining weekly weights (#3). The findings are: 1. Review of Resident #1's current FL2 dated 02/07/22 revealed: -Diagnoses included confusion, recurrent right inguinal hernia, and cero-vascular accident. -The resident was intermittently disoriented. -There was an order for daily blood pressure (BP) checks. Review of Resident #1's addendum to FL2 dated 02/18/22 revealed abnormal neurological confusion was documented. Review of Resident #1's Resident Register revealed an admission date of 02/27/22. Review of Resident #1's February 2022, March 2022 and April 2022 electronic medication administration records (eMAR) revealed there were no entries for daily BP checks. Review of Resident #1's weights and vital summary revealed Resident #1's blood pressure was documented on 03/02/22 at 4:52pm as 134/90 in the right arm standing. Telephone interview with Resident #1's primary care provider (PCP) on 04/26/22 revealed: -Resident #1's daily blood pressure checks were order to get a baseline for the resident. -The facility should be taking and recording the blood pressure daily as ordered. -He did not take blood pressure medication. Review of a BP check for Resident #1 on 04/29/22 at 9:36am sitting revealed Resident #1's	D 276		

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D 276	Continued From page 41 BP was 122/64. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Attempted telephone interview with the HWD on 04/29/22 at 10:05am was unsuccessful. Refer to the interview with the facility's contracted Registered Nurse (RN) on 04/26/22 at 3:56pm. Refer to the interview with the Administrator on 04/26/22 at 4:17pm. Refer to the interview with a Supervisor/medication aide (S/MA) on 04/29/21 at 10:13am. 2. Review of Resident #3's current FL2 dated 07/02/21 revealed: -Diagnoses included anxiety, coronary artery disease, and Alzheimer's dementia. -The resident was constantly disoriented, non-ambulatory and used a wheelchair. Review of Resident #3's physician's orders dated 09/13/21 noted Resident #3 had recent weight loss start weights weekly. Review of Resident #3's subsequent physician's orders revealed there was no order to discontinue weekly. Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed: -Ensure liquid one can two times a day was listed and scheduled for administration at 8:00am and 8:00pm daily.	D 276		

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D 276	Continued From page 42 -Ensure liquid was documented as administered from at 8:00am and 8:00pm from 02/01/22/to 02/15/22. -Ensure liquid was discontinued on 02/16/22. Review of Resident #3's February 2022, March 2022, and April 2022 eMARs revealed: -Weekly weights was not listed on the eMARS. -There was no documentation weekly weights were obtained as ordered for 02/01/22 to 04/27/22. Review of the Resident #3's facility's Progress Notes used to document medications and changes for the residents revealed: -On 09/14/21, a "weight change note" was entered by the Health and Wellness Director (HWD) documenting a weight of 118.5 pounds. Resident on nutrition at risk, weight to measured weekly and ensure twice a day to be given. Family and MD aware of changes. -On 10/12/21, a "weight change note" was entered by the HWD documenting a weight of 118. "Resident on nutrition at risk, weight to measured weekly and ensure given. Family and MD aware of changes". -On 11/28/21, a "weight change note" was entered by the HWD documenting a weight of 118 pounds. -On 02/06/22, a "weight change note" was entered by the HWD documenting a weight of 128 pounds. -On 02/16/22, a "weight change note" was entered by the HWD documenting a weight of 129.5 pounds. -On 02/28/22, a "weight change note" was entered by the HWD documenting weight of 136 pounds for a 10% weight gain. "MD and family aware of change"	D 276		

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D 276	Continued From page 43 Review of the facility's Weights and Vitals summary for Resident #3's from 09/11/21 to 04/12/22 revealed: -Weights were documented 09/11/21, 09/27, 21, 10/04/21, 10/11/21, 11/04/21, 11/08/21, 12/02/21, 12/06/21, 01/05/21, 02/23/22, 03/15/22, and 04/12/22. -The weight range was from 118.5 pounds on 09/11/21 to 132 pounds on 04/12/22. Review of Resident #3 weight on 04/29/22 at 10:35am was 127 pounds. Telephone interview with Resident #3's primary care provider (PCP) on 04/29/22 at 8:20am revealed: -Resident #3 had an order weekly weights documented dated 09/12/21 in the resident's clinical notes. -There was no documentation Resident #3's weekly weights were discontinued in the resident's notes. -Without seeing the resident and obtaining a current weight, she would not discontinue the weekly. -The facility should be obtaining weekly weights and documenting the weights to assist with monitoring her nutritional status. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Refer to the interview with the facility's contracted Registered Nurse (RN) on 04/26/22 at 3:56pm. Refer to the interview with the Administrator on 04/26/22 at 4:17pm. Refer to the interview with a	D 276		

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D 276	Continued From page 44 Supervisor/medication aide (S/MA) on 04/29/21 at 10:13am. Interview with the facility's contracted Registered Nurse (RN) on 04/26/22 at 3:56pm revealed: -The Health and Wellness Director (HWD) was the facility nurse. -The HWD was responsible to ensure orders for task, like daily blood pressure checks, daily or weekly weights, orders for physical therapy or skilled nursing, were implemented if ordered. -The facility's medication aides(MA) did not routinely enter the health care related orders. Interview with the Administrator on 04/26/22 at 4:17pm revealed: -The HWD was responsible for ensuring FL2 information and any addendums to the FL2 were entered into the facility's Point-Click-Care (PCC) system and the systems' electronic medication administration record (eMAR) was accurate and included any ordered task. -There was an order tracking system in place that provided documentation for the staff entering information from FL2 upon admission to new orders. -The system called for a 2 person check for information entered including information entered by the HWD. -Orders were not being properly entered and doubled checked per procedure. Interview with a Supervisor/medication aide (S/MA) on 04/29/21 at 10:13am revealed: -The HWD routinely entered orders from the residents' admitting FL2, addendums to the FL2 and physician's ordered she obtained from health care discussion with the primary care providers (PCPs). -The HWD entered orders for task, like weights	D 276		

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D 276	Continued From page 45 and blood pressure checks, into the eMAR system to document the results. -It an order was not entered into the eMAR system the MA would not know to administer the order. -The facility routinely obtained vital signs monthly for residents.	D 276		
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, interviews and record reviews the facility failed to ensure therapeutic diets were served as ordered for 2 of 5 sampled residents (#3, #6) including a resident with an order for a pureed liberal renal diet (#6) and a resident with an order for a nutritional supplement (#3). The findings are: 1. Review of Resident #6's current FL-2 dated 01/14/22 revealed no diagnoses or diet. Review of Resident #6's facility's diet order form dated 01/14/22 revealed: -Diet type was a liberalized renal diet. -Diet consistency was a pureed diet.	D 310		

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D 310	Continued From page 46 -A liberalized renal diet was defined as limited sodium, potassium, and phosphorous, with adequate calories and protein. Review of the diets posted on the kitchen wall on 04/26/22 at 12:19pm revealed: -There were listings for pureed diet, carb control diet, finger foods, and double portions. -There were no residents listed for a liberalized renal diet. -Resident #6 was listed under the pureed diet list. Review of the facility's nutrition tracker report dated 04/14/22 revealed Resident #6 was listed as a pureed diet; liberalized renal diet was not listed. Review of the facility's menu spreadsheet provided on 04/26/22 revealed: -There were 5 diet columns that could be reviewed, carbohydrate-controlled, low fat/cholesterol, pureed diet, texture modified, and finger food. -There was a 6th column that could not be read based on the printing on the document, the entire column was not printed. Observation of Resident #6's dinner meal service on 04/26/22 at 5:22pm revealed the resident was served multiple bowls of pureed food. Review of the facility's spreadsheet in the computer system on 04/28/22 at 9:05am revealed the 6th column was labeled as liberalized renal diet and the 7th column was labeled as a 2-gram sodium diet. Interview with the Dietary Manager (DM) on 04/28/22 at 9:05am revealed: -He did not have any residents on the diets for the	D 310		

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D 310	Continued From page 47 columns that did not print (liberalized renal and 2gram sodium). -The facility's nurse provided the nutritional tracker with the resident's diets listed. -He was supposed to be given a diet form for each resident, but he did not always get those. -He did not have a diet order form for Resident #6. -Resident #6 was on a pureed diet. -He pureed a regular diet for Resident #6. -He did not know Resident #6 had an order for a liberalized renal diet. -If he had seen Resident #6's diet order form he would have made sure the menu spreadsheet would have printed out the column for directions on the diet. Interview the facility's contracted Register Nurse (RN) on 04/28/22 at 9:23am revealed: -She had been working at the facility since late March 2022. -When a resident was admitted to the facility there should be a diet order. -A copy of the diet order should be given to the DM, put into the point and click computer system, and in the resident's record. -New residents' diet orders or changes in a diet order were discussed at stand-up meetings with staff. -She did not know why Resident #6 was on a liberalized renal diet. -She would have to see if check the resident's kidney function to make sure there had been no harm to the resident. Interview with the Administrator on 04/28/22 at 9:38am revealed: -Obtaining diet orders were part of the move-in process. -The diet order was an addendum to the FL-2.	D 310		

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D 310	Continued From page 48 -The diet was entered into the point-and-click computer system by the clinical team. -A copy of the diet order should be given to the dietary department. -If the DM was not in the facility when the resident moved in, the order should be given to the cook so they would know what to prepare. He was concerned about the lack of follow-through with this process. -The initial order was not provided to the dining services as it should have been. -A liberalized renal diet was not a common diet and would need to be clarified if the resident needed this diet but should be followed until it was clarified. Telephone interview with Resident #6's primary care provider on 04/28/22 at 10:16am revealed: -Resident #6 had a history of elevated potassium so that may have been the reason she chose the liberalized renal diet. -Resident #6's potassium had improved since then and the resident could probably be administered a regular diet. -She would have expected Resident #6's liberalized renal diet order to have been followed or staff to have called for clarification on the diet order. 2. Review of Resident #3's current FL2 dated 07/02/21 revealed: -Diagnoses included anxiety, coronary artery disease, and Alzheimer's dementia. -The resident was constantly disoriented, non-ambulatory and used a wheelchair. Review of Resident #3's physician's orders dated 09/13/21 revealed Resident #3 had recent weight loss, start weights weekly and a nutritional supplement to be given twice a day.	D 310		

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D 310	Continued From page 49 Review of Resident #3's signed physician's orders dated 01/12/22 and 04/06/22 revealed [named nutritional supplement] give one can 2 times a day related to Alzheimers's disease with late onset. Review of Resident #3's subsequent physician's orders revealed there was no order to discontinue the nutritional supplement 2 cans a day. Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed: -Nutritional supplement one can two times a day was listed and scheduled for administration at 8:00am and 8:00pm daily. -Nutritional supplement was documented as administered from at 8:00am and 8:00pm from 02/01/22/to 02/15/22. -Nutritional supplement was discontinued on 02/16/22. Review of Resident #3's March 2022 and April 2022 eMARs revealed: -Nutritional supplement was not listed on the eMARs. -There was no documentation nutritional supplement was administered from 03/01/22 to 04/27/22. Review of the Resident #3's facility's progress notes used to document medications and changes for the residents revealed: -On 09/14/21, a "weight change note" was entered by the Health and Wellness Director (HWD) documenting a weight of 118.5 pounds. Resident on nutrition at risk, weight to be measured weekly and [nutritional supplement] twice a day to be given. Family and medical doctor (MD) aware of changes.	D 310		

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D 310	Continued From page 50 -On 10/12/21, a "weight change note" was entered by the HWD documenting a weight of 118. "Resident on nutrition at risk, weight to be measured weekly and [nutritional supplement] given. Family and MD aware of changes." -On 11/28/21, a "weight change note" was entered by the HWD documenting a weight of 118 pounds. -On 02/06/22, a "weight change note" was entered by the HWD documenting a weight of 128 pounds. -On 02/16/22, a "weight change note" was entered by the HWD documenting a weight of 129.5 pounds. -On 02/28/22, a "weight change note" was entered by the HWD documenting weight of 136 pounds for a 10% weight gain. "MD and family aware of change, [nutritional supplement] d/c [discontinued]." Interview with the Dietary Manager (DM) on 04/26/22 at 12:19pm revealed: -He ordered nutritional supplements for residents who had an order. -He provided the nutritional supplements to the medication aides (MA). -When the MA needed a nutritional supplement they were stored in the refrigerator in the medication room. Observation of the reach in cooler in the kitchen and the refrigerator in the medication room on 04/26/22 at 12:19pm revealed multiple boxes and individual containers of nutritional supplements. Interview with a Supervisor/medication aide (S/MA) on 04/29/21 at 10:13am revealed: -The HWD entered the order on 09/20/21 into the facility's computer system for Resident #3's nutritional supplement according to	D 310		

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D 310	Continued From page 51 documentation on the computers order tracking. -The HWD discontinued Resident #3's order for nutritional supplement on 02/16/22 from the eMAR. -The MAs were responsible to ensure nutritional supplements were administered as ordered on the eMARs. -Resident #3 was not being administered nutritional supplement if it did not show up on the eMAR for administration. Telephone interview with Resident #3's primary care provider (PCP) on 04/29/22 at 8:20am revealed: -Resident #3 had an order for a nutritional supplement that started on September 2021 and was documented in the resident's clinical notes. -There was no documentation Resident #3's nutritional supplement was discontinued in the resident's notes. -Nutritional supplement was listed in Resident #3's current medications. -If the HWD discontinued the nutritional supplement due to a stable weight it should have been ordered discontinued in the clinical notes she was viewing. -Without seeing the resident and obtaining a current weight, she would not discontinue the nutritional supplement. Telephone interview with Resident #3's family member revealed: -The cost of the nutritional supplement was a lot each month. -He was in favor of discontinuing the medication since Resident #3 had gained weight again. -He did not know if an order to discontinue the nutritional supplement was needed or obtained. Interview with the Administrator on 04/29/22 at	D 310		

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D 310	Continued From page 52 12:30pm revealed: -Resident #3 was most likely placed on a nutritional supplement if she had weight loss in September 2021. -The HWD was responsible to ensure all documentation for orders and treatments was available for review. -The HWD should have an order available for review for discontinuing the nutritional supplement. -If there was no order available the facility would ensure Resident #3 was evaluated by the PCP for the nutritional supplement to be restarted or discontinued.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 residents (#6 and #7) observed during the medication pass including errors with a medication to treat dementia (#7) and a medication to treat constipation (#6); and for 2 of 5 residents (#3 and #4) sampled for record review including errors with a scheduled pain medication (#3) and medication for cramping (#4).	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 53 The findings are: 1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 27 opportunities during the 8:00am medication pass on 04/27/22. a. Review of Resident #7's current FL2 dated 03/04/22 revealed: -Diagnoses included dementia, anxiety, and depression. -There was an order for Namenda (used to treat dementia) 10mg twice a day. Observation of the medication pass for Resident #7 on 04/27/22 revealed: -At 9:10am, the morning medication aide (MA) prepared 4 oral medications for administration to Resident #7. -Namenda 10mg was not one of the medications prepared. Review of Resident #7's April 2022 electronic medication administration record (eMAR) revealed there was no entry for Namenda 10mg on the eMAR. Observation of medication on hand for administration for Resident #7 on 04/27/22 revealed: -There was a prescription bottle of Namenda 10mg dispensed from a local pharmacy. -The bottle was labeled for Namenda one tablet twice a day, dispensed on 03/14/22 for 180 tablets. -The bottle was full. Interview with a lead medication aide (MA) on 04/27/22 at 11:00am revealed:	D 358		

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D 358	Continued From page 54 -The Health and Wellness Director (HWD) was a nurse. -The HWD was responsible for entering residents' medication orders, including the orders from the FL2 dated 03/04/22 for Resident #7. -The HWD had entered Resident #7's medications into the eMAR system at admission as was documented in the eMAR system. -The MAs entered orders when the HWD was not at the facility, and on weekends. -The orders entered by the MAs were checked by the HWD or another MA. -The orders entered by the HWD were not checked by another staff as far as she knew. -The HWD or another MA must have put Resident #7's medications on the medication cart and did not recognize Namenda 10 mg was left off the eMAR. Interview with the MA that administered Resident #7's medications during the 8:00am medication pass on 04/27/22 at 11:23am revealed: -She did not enter medication orders into the eMAR system. -She did not see medication orders routinely. -She administered medications according to the eMAR computer screen. -If a medication did not appear on the eMAR screen at an assigned time, she would not know to administer the medication. Interview with a medication aide/Supervisor (MA/S) on 04/27/22 at 11:39am revealed: -The HWD entered Resident #7's admission orders and it looked like she left Namenda 10mg twice a day off the eMAR. -The family provided Resident #7's medications from an outside pharmacy. -The facility's eMAR system was not the same one used by the contract pharmacy provider.	D 358		

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D 358	Continued From page 55 -The facility faxed copies of medication orders and the FL2s for the contracted pharmacy to use in maintaining a drug profile for the residents. -The HWD and the MA/S conducted audits for medications on hand compared to the eMAR and for out of date medications at random times. -The HWD was no longer working at the facility since the middle of April 2022. -The MA/S had not audited the medication cart with Resident #7's medications since the resident was admitted in March 2022 (date of admission was blank on the Resident Register). Telephone interview with a nurse at Resident #7's primary care provider's (PCP) office on 04/27/22 at 11:56am revealed: -Resident #7 was ordered Namenda 10mg on the FL2 dated 03/04/22. -There was no subsequent physician's order to discontinue Namenda 10mg. -Resident #7 should be receiving Namenda 10mg twice a day as ordered. Interview with the Administrator on 04/26/22 at 4:17pm revealed: -The Health and Wellness Director (HWD) was the facility's nurse. -The HWD was responsible to enter orders for medications and/or treatments and to check orders entered by the facility's MAs. -There was a system in place to enter all new orders, including treatments, onto a new order tracking form for documentation of entering orders in the eMAR system; then a second staff member verified the accuracy and completion of the order enter with documentation. -The system was to be used by all staff including the HWD with a staff member checking the HWD's entries. -There was no documentation the HWD followed	D 358		

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D 358	Continued From page 56 the system for orders she entered. -He was concerned there was a lack of follow-up, training on the process for using the new order tracking form and things were not getting done. Based on observations, interviews and record reviews, it was determined Resident #7 was not interviewable. b. Review of Resident #6's current FL-2 dated 01/14/22 revealed: -There were no diagnoses listed. -There was an order for docusate sodium 100mg 2 capsules (200mg) one time a day related to constipation (Docusate sodium is a stool softener). Review of Resident #6's facility order summary report dated 04/13/22 revealed diagnoses included constipation, insomnia, dementia without behavioral disturbances, and major depressive disorder. Observation of the medication pass for Resident #6 on 04/27/22 revealed: -At 9:25am, the morning medication aide (MA) prepared 3 oral medications for administration to Resident #6. -The MA used an over the counter stock bottle of combination stool softener each tablet containing docusate 50mg/sennosides 8.6mg (sennosides is a laxative) to prepare 4 tablets to equal 200mg of docusate sodium. Review of Resident #6's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for docusate sodium 100mg take 2 capsules on time a day for constipation listed and scheduled for administration at 8:00am	D 358		

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D 358	Continued From page 57 daily. -Docusate sodium 200mg was documented as administered daily at 8:00am from 04/01/22 to 04/27/22. Observation of medication on hand for administration for Resident #6 on 04/27/22 revealed there was a partial over the counter stock bottle of combination stool softener each tablet containing docusate 50mg/sennosides 8.6mg quantity of 400 tablets with 150 tablets remaining. Interview the facility's contracted Register Nurse (RN) on 04/27/22 at 11:00am revealed: -It was the responsibility of the Health and Wellness Director (HWD) who was a nurse to check medications supplied by family members for being a therapeutic equivalent (same) product to the medication ordered. -The HWD could appoint another person to assist with approving medications. Interview with the MA that administered Resident #6's medications during the 8:00am medication pass on 04/27/22 at 9:35am revealed: -Resident #6's family provided the docusate sodium from a community pharmacy. -The container was handwritten to administer 4 capsule each one containing 50mg of docusate sodium per the label. -She administered 4 capsules as the dose ordered. Interview with a medication aide/Supervisor (MA/S) on 04/27/22 at 11:39am revealed: -The HWD and she conducted audits for medications on hand compared to the eMAR. -The HWD was no longer working at the facility since the middle of April 2022.	D 358		

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D 358	Continued From page 58 -The MA/S had not audited the medication cart with Resident #6's medications since Resident #6's family brought the over the counter stock bottle of combination stool softener each tablet containing docusate 50mg/sennosides 8.6mg to the facility for Resident #6. Second interview with the MA that administered Resident #6's medications during the 8:00am medication pass on 04/27/22 at 11:35am revealed she overlooked that the over the counter stock bottle of combination stool softener each tablet containing docusate 50mg/sennosides 8.6mg used to prepare 4 tablets to equal 200mg of docusate sodium was not the same as plain docusate sodium 100mg. Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. 2. Review of Resident #3's current FL2 dated 07/02/21 revealed: -Diagnoses included anxiety, coronary artery disease, and Alzheimer's dementia. -The resident was constantly disoriented, non-ambulatory and used a wheelchair -There was an order for Norco 5/325mg (a schedule II narcotic used for moderate to severe pain) at bedtime. Review of Resident #3's signed physician's orders dated 01/12/22 and 04/06/21 revealed Norco 5/325 one tablet at bedtime for pain was ordered. Review of Resident #3's Resident Register revealed an admission date of 06/21/19. Telephone interview with a pharmacist at the	D 358		

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D 358	Continued From page 59 facility's contracted pharmacy revealed: -The facility was responsible for reordering controlled narcotic pain medications. -The pharmacy sent a controlled substance count sheet (CSCS) with each dispensing of the controlled medications. -When the facility reordered a controlled narcotic pain medication like Norco, a new medication order was required unless the previous order was partially filled. -The pharmacy notified the facility that a medication order was required by sending a medication reorder form for the facility to fax or give to the primary care provider (PCP) to reorder the medication. -Resident #3 was dispensed Norco 5/325mg as follows: -On 01/31/22, Resident #3 was dispensed Norco 5/325 with directions for one tablet at bedtime and a quantity of 30 tablets. -On 03/14/22, Resident #3 was dispensed Norco 5/325 with directions for one tablet at bedtime and a quantity of 30 tablets. -On 04/18/22, Resident #3 was dispensed Norco 5/325 with directions for one tablet at bedtime and a quantity of 30 tablets. Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed there was an entry for Norco 5/325 scheduled for administration at 8:00pm and documented as administered daily from 02/01/22 through 02/28/22. Review of Resident #3's CSCS for Norco 5/325 dispensed for 30 tablets on 01/31/22 revealed the medication was signed out for one tablet daily at 8:00pm from 02/01/22 to 02/28/22 (28 tablets). Review of Resident #3's March 2022 eMAR	D 358		

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D 358	Continued From page 60 revealed: -There was an entry for Norco 5/325 scheduled for administration daily at 8:00pm. -Norco 5/325 was documented as administered at 8:00pm on 03/01/22 and 03/02/22. -Norco 5/325 was documented as not administered at 8:00pm from 03/03/22 to 03/14/22 for 12 doses. -Norco 5/325 was documented as administer at 8:00pm from 03/15/22 through 03/31/22. Review of Resident #3's CSCS for Norco 5/325 dispensed for 30 tablets on 01/31/22 revealed Norco 5/325 was signed out for one tablet daily at 8:00pm on 03/01/22 and 03/02/22. Review of Resident #3"s medication progress notes revealed Norco 5/325 was documented from 03/03/22 through 03/14/22 as medication not in house, medication not in home, medication not on cart, on order, medication not available, and/or medication not on cart will contact the pharmacy for reason not administered as ordered. Review of Resident #3's April 2022 eMAR revealed: -There was an entry for Norco 5/325 scheduled for administration daily at 8:00pm. -Norco 5/325 was documented as administered at 8:00pm on 04/01/22 and 04/13/22. -Norco 5/325 was documented as not administered at 8:00pm from 04/14/22 through 04/18/22 for 5 doses. -Norco 5/325 was documented as administer daily at 8:00pm from 04/19/22 through 04/27/22. Review of Resident #3"s medication progress notes revealed Norco 5/325 was documented from 04/14/22 through 04/18/22 (5 doses) as	D 358		

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D 358	Continued From page 61 waiting on order, medication not in home, waiting on script (prescription) and/or waiting on medications to arrive for reason not administered as ordered. Review of Resident #3's CSCS for Norco 5/325 dispensed for 30 tablets on 03/14/22 revealed Norco 5/325 was signed out for one tablet daily at 8:00pm from 03/15/22 through 04/13/22 (30 tablets). Review of Resident #3's CSCS for Norco 5/325 dispensed for 30 tablets on 04/18/22 revealed Norco 5/325 was signed out for one tablet at 8:00pm from 04/18/22 through 04/27/22 (9 tablets). Observation of Norco 5/325 available for administration to Resident #3 on 04/27/22 at 3:00pm revealed there were 21 tablets remaining which matched the quantity on hand on the CSCS for 04/18/22. Interview with a second shift MA on 04/28/22 at 4:10pm revealed: -She administered Resident #3's Norco 5/325 the evenings she worked. -Resident #3 had ran out of Norco 5/325 at the end of the last couple of monthly orders. -The MAs were supposed to reorder Resident #3's Norco 5/325 when there were 7 tablets remaining. -The pharmacy would send a sheet notifying the facility a hard copy was needed to send the Norco 5/325 along with an order request that could be faxed to Resident #3's primary care provider (PCP) requesting a new hard copy of the order. -Some the MAs were not faxing the medication request to the provider. -She did not know where some of the pharmacy	D 358		

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D 358	Continued From page 62 notifications for new orders required ended up. -She would come back after being off a couple of days and Resident #3 would still be out of Norco 5/325. -She had faxed a request to Resident #3's PCP if she had not worked for a couple of days and came back she found there was no Norco 5/325 from the pharmacy and nobody seemed to know why. -The Health and Wellness Director (HWD) was responsible to ensure residents received medications as ordered. -She reported Resident #3 did not have Norco to the HWD at least 2 times (during the March 2022 outage) but she did not see the medication arrive for a long time. Telephone interview with Resident #3's PCP on 04/29/22 at 8:20am revealed: -She did not know Resident #3 had been without Norco 5/325 for 12 days in March 2022 and 5 days in April 2022. -The facility should let her know by faxing the clinic or leaving a message on the contact line for a call back. -There was an on-call triage nurse for 24 hours a day 7 days a week. -She could be reached during regular weekdays by leaving a message. -There were no notes regarding Resident #3 not having Norco 5/325 orders for refills. -She expected the facility to ensure timely reorder of Norco 5/325 for Resident #3 not to run out. Telephone interview with Resident #3's family member (Power of Attorney) on 04/29/22 at 10:35am revealed: -He was at the facility to see Resident #3 at least 3 to 5 times a week. -He was not sure why Resident #3 had a	D 358		

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D 358	Continued From page 63 long-term order for Norco 5/325 for pain. -He had never seen Resident #3 acting as if she was in pain or complaining she was hurting. -If Resident #3 had gone several days occasionally without Norco 5/325 he had not been able to tell any change during his visits. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. 3. Review of Resident #4's current FL-2 dated 04/13/22 revealed: -Diagnoses included Alzheimer's disease, type II diabetes mellitus, abnormalities of gait, and mobility. -There was an order for Magnesium Chloride (used to treat leg cramps) 64mg daily. Review of Resident #4's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Magnesium Chloride 64mg twice a day with a scheduled administration time of 8:00am and 8:00pm. -Magnesium Chloride 64mg was documented as administered at 8:00pm on 04/07/22 and at 8:00am and 8:00pm from 04/08/22-04/24/22 and at 8:00am on 04/25/22. -There were exceptions documented from 04/25/22-04/28/22 with the reason documented as see other/nurse's notes. Review of Resident #4's electronic progress notes dated 04/25/22 revealed Magnesium Chloride was not in the facility. Observation of Resident #4's medications on hand on 04/27/22 at 2:44pm revealed there was no Magnesium Chloride available to be	D 358		

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D 358	Continued From page 64 administered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/27/22 at 3:12pm revealed: -Resident #4 was dispensed 21 tablets of Magnesium Chloride 64 mg to be administered once a day on 04/13/22 that would have lasted for 21-days "to get through the batch." -There was no order in their system for Magnesium Chloride twice daily. -There had been no requests to refill Resident #4's Magnesium Chloride, but the medication was scheduled to go out on the next batch. Interview with a lead medication aide (MA) on 04/28/22 at 4:41pm revealed: -Resident #4's Magnesium Chloride had been entered into the eMAR by the previous Health and Wellness Director (HWD). -The order frequency was entered as twice a day for the Magnesium Chloride. -If the order had changed, she would see it in the eMAR system; the order had not been changed. -The HWD entered the order and confirmed the order on 04/07/22. Telephone interview with Resident #4's primary care provider (PCP) on 04/28/22 at 8:40am revealed: -Resident #4 had a low magnesium level and a history of leg cramps. -Resident #4's Magnesium Chloride had not been changed to twice a day. -Resident #4's current order was Magnesium Chloride 64mg once daily. -She was not aware Resident #4 had been administered Magnesium Chloride twice a day. -Resident #4 could experience loose stool and gastrointestinal problems (nausea/vomiting).	D 358		

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D 358	Continued From page 65 -She expected Resident #4's Magnesium Chloride to be administered as ordered. -Resident #4 could experience leg cramps if he went without the medication. -Her residents should never go without medication a refill should have been requested. Interview with Resident #4 on 04/28/22 at 4:51pm revealed: -He did not know what medications he took; he took what he was given. -He had problems with leg cramps, but it had been a while since he had any cramps. -He had loose stools a couple of times, "not too far back." -He had not told anyone he had loose stools. -He had nausea, but not as often as the loose stools. Interview with a MA on 04/28/22 at 4:57pm revealed: -She used the eMAR to administer a resident's medication. -She matched the medication on hand to the eMAR. -She had not noticed Resident #4's Magnesium Chloride label had the directions to administer once a day and the eMAR had twice a day. -Had she noticed she would have called for clarification. -She should have noticed the prescription label and the eMAR did not match. Interview with the Supervisor in Charge (SIC)/MA on 04/29/22 at 9:49am revealed: -She had not completed a cart audit since February 2022. -She only had one day a week for administrative duties and on other days she worked on the medication cart.	D 358		

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D 358	Continued From page 66 -When she did a cart audit, she compared the medication on hand to what was in the eMAR and if the medication did not match, she would call the pharmacy for clarification. -She had administered Resident #4's Magnesium Chloride. -She did not notice the punch card dispensed from the pharmacy was labeled for once daily. -She should have seen the discrepancy. -Had she seen the discrepancy, she would have compared it to the FL-2 and clarified. -When medication was not on hand to be dispensed the MA should contact the pharmacy. -If a medication was ordered before noon, it would be delivered the same day. Interview the facility's contracted Register Nurse (RN) on 04/29/22 at 11:00am revealed: -She had been working at the facility since late March 2022. -All MAs were able to input orders into the eMAR. -All orders input into the eMAR, were to have a second person review. -There was a new order and tracking form that was used to track orders to ensure the order form and the eMAR matched. -There were no exceptions to the second-person review because anyone could make a mistake. -She was concerned the MAs were administering medication without making sure the medication label matched the eMAR. Review of the new order tracking notebook on 04/29/22 at 11:57am revealed there was no order tracking form completed on Resident #4's Magnesium Chloride. Second interview with the SIC/MA on 04/29/22 at 11:47am revealed the new order tracking form was not used on new admissions, they just used	D 358		

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D 358	Continued From page 67 the resident's FL-2 to input orders. Interview with the Administrator on 04/29/22 at 12:40am revealed: -Orders from a resident's FL-2 were entered into the eMAR by staff and reviewed by a second set of eyes before being approved. -The procedure was always reviewed by a second set of eyes. -The FL-2 was then faxed to the pharmacy. -When medication was delivered from the pharmacy, the medication would be verified that it matched. -There should be no discrepancies. -When the medication was administered, he expected the MA to look at the eMAR to see what was scheduled to be administered, pull the medication, and use 3 checks to verify the medication being administered was correct. -He was concerned who entered and verified Resident #4's Magnesium Chloride had not followed the procedure. -He was concerned when the medication was administered, it was not done correctly based on the order when the eMAR did not match the prescription. -He was concerned the medication was not available to be administered, and the pharmacy had not been contacted.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be	D 392		

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D 392	Continued From page 68 accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record, including medication administration records (MARS) and controlled substances count sheet (CSCS) that accurately reconciled the receipt, administration, and disposition of a controlled medication was maintained for 1 of 3 sampled residents related to an anti-anxiety medication (#3). The findings are: Review of Resident #3's current FL2 dated 07/02/21 revealed: -Diagnoses included anxiety, coronary artery disease, and Alzheimer's dementia. -The resident was constantly disoriented, non-ambulatory and used a wheelchair. -There was an order for Ativan (a schedule IV controlled substance used to treat anxiety) 0.5mg three times a day as needed. (Lorazepam is generic for Ativan). Review of Resident #3's signed physician's orders dated 01/12/22 and 04/06/21 Ativan 0.5mg three times a day as needed. was ordered. Review of Resident #1's Resident Register revealed an admission date of 06/21/19. Telephone interview with an order entry staff at the facility's contracted pharmacy on 04/28/22 at 4:28pm revealed: -The pharmacy sent controlled substance count sheets (CSCS) with all controlled substance	D 392		

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D 392	Continued From page 69 dispensed by the pharmacy. -The CSCS was used to maintain a decreasing inventory tracking as the medication was signed out and along with the facility's medication administration record was used as a readily retrievable record of receipt, administration, and disposition of the controlled substance. -The pharmacy records documented Resident #3 was dispensed lorazepam 0.5mg tablets as follows: -On 10/14/20, lorazepam 0.5mg with instructions for one tablet every day as needed for anxiety was dispensed for a quantity of 30 tablets. -On 10/20/20, lorazepam 0.5mg with instructions for one tablet 3 times a day, as needed for agitation was dispensed for a quantity of 12 tablets. -On 12/22/20, lorazepam 0.5mg with instructions for one tablet every day as needed for anxiety was dispensed for a quantity of 30 tablets. -On 03/07/22, lorazepam 0.5mg with instructions for one tablet every day as needed for anxiety was dispensed for a quantity of 30 tablets. Interview with the Business Office Manager (BOM) on 04/28/22 at 4:52pm revealed: -She worked as a medication aide (MA) at the facility prior to becoming the BOM. -Medications administered as needed (prn) were documented on the eMAR and signed out on the CSCS when administered. -The eMAR prompted a response for effectiveness beginning one hour after administration. The documentation for effectiveness was recorded in the residents' progress notes with the facility's "Point-Click-Care (PCC) computer system linked to the eMARs. -If a medication (controlled or non-controlled) was administered as a prn, and documented on the eMAR it appeared on the progress notes and	D 392		

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D 392	Continued From page 70 could be used to track the prn administration of a medication. Review of Resident #3's CSCS for lorazepam 0.5mg quantity of 30 tablets dispensed on 10/14/20 compared to the the resident's progress notes revealed: -There was a beginning balance of 30 lorazepam 0.5mg tablets on 10/14/20 on the CSCS. -From 10/16/20 to 02/12/22 there was documentation 21 lorazepam 0.5mg tablets were signed out on the CSCS which corresponded to 21 doses of lorazepam 0.5mg documented for administration and effectiveness on Resident #3's progress notes for medications. -There were no additional lorazepam 0.5mg tablets documented as administered after 02/17/22. -There was an ending balance of 9 lorazepam 0.5mg tablets documented on the CSCS on 02/12/22. -There was no documentation for the disposition of the remaining 9 lorazepam 0.5mg tablets for 30 tablets dispensed on 10/14/20 resulting in 9 lorazepam 0.5mg tablets not accounted for. Observation of medication on hand for administration for Resident #3 on 04/28/22 at 3:45pm revealed the 9 remaining lorazepam 0.5mg tablets from the dispensing on 10/14/20 were not available for administration. Review of Resident #3's CSCS for lorazepam 0.5mg quantity of 30 tablets dispensed on 10/20/20 compared to the the resident's progress notes revealed: -There was a beginning balance of 12 lorazepam 0.5mg tablets on 10/20/20 on the CSCS. -From 11/01/20 to 02/09/22 there was documentation 3 lorazepam 0.5mg tablets were	D 392		

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D 392	Continued From page 71 signed out on the CSCS which corresponded to 3 doses of lorazepam 0.5mg documented for administration and effectiveness on Resident #3's progress notes for medications. -There were no additional lorazepam 0.5mg tablets documented as administered after 02/09/21 on the CSCS. -There was an ending balance of 9 lorazepam 0.5mg tablets documented on the CSCS on 02/09/21. -There was no documentation for the disposition of the remaining 9 lorazepam 0.5mg tablets for 30 tablets dispensed on 10/20/20 resulting in 9 lorazepam 0.5mg tablets not accounted for. Observation of medication on hand for administration for Resident #3 on 04/28/22 at 3:45pm revealed the 9 remaining lorazepam 0.5mg tablets from the dispensing on 10/20/20 were not available for administration. Review of Resident #3's CSCS for lorazepam 0.5mg quantity of 30 tablets dispensed on 12/22/20 compared to the the resident's progress notes revealed: -There was a beginning balance of 30 lorazepam 0.5mg tablets on 12/20/20 on the CSCS. -There was no lorazepam 0.5mg tablets signed out on the CSCS and no lorazepam 0.5mg tablets documented for administration and effectiveness on Resident #3's progress notes for medications in addition to the tablets already documented from previous lorazepam 0.5mg inventory. -There was an ending balance of 30 lorazepam 0.5mg tablets documented on the CSCS. -There was no documentation for the disposition of the 30 tablets dispensed on 12/22/20 resulting in 30 lorazepam 0.5mg tablets not accounted for. Observation of medication on hand for	D 392		

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D 392	Continued From page 72 administration for Resident #3 on 04/28/22 at 3:45pm revealed there were no lorazepam 0.5mg tablets available for administration from the dispensing on 12/22/20. Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed: -Lorazepam 0.5mg one tablet 3 times a day as needed for anxiety was listed and scheduled as needed (prn). -Lorazepam 0.5mg was documented as administered on 02/12/22 at 1:45am and was effective. (Documented on Resident #3's progress notes). Review of Resident #3's March 2022 and April 2022 eMARS revealed: -Lorazepam 0.5mg one tablet 3 times a day as needed for anxiety was listed and scheduled as needed (prn). -There were no Lorazepam 0.5mg tablets documented as administered from 03/01/22 to 04/27. Observation of medication on hand for administration for Resident #3 on 04/28/22 at 3:45pm revealed there were 30 lorazepam 0.5mg tablets available for administration from the dispensing on 03/07/22. Telephone interview with a representative for the controlled substance return department of the facility's contracted pharmacy on 04/29/22 at 9:20am revealed: -The facility was provided a controlled substance return form for documenting the return of controlled substances for credit or destruction. -The facility should keep a copy of the returned controlled drug form for their records which would	D 392		

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D 392	Continued From page 73 provide a date of the return. -The pharmacy tracked the controlled substances returned by the facility by the date returned. -She queried the pharmacy's return data for lorazepam 0.5mg returned but was not able to find any for Resident #3. -There was no documentation the facility returned lorazepam 0.5mg for 9 tablets dispensed on 10/14/20, lorazepam 0.5mg for 9 tablets dispensed on 10/20/20 or lorazepam 0.5mg for 30 tablets dispensed on 12/20/20. -The facility could have destroyed the medication using the pharmacy supplied drug destruction liquid but the facility should have a record of the destruction. Review of the facility's pharmacy packing lists and returns documentation on 04/29/22 revealed there was no documentation available to account for the 48 lorazepam 0.5mg not available for administration. Telephone interview with the previous Health and Wellness Director (HWD) on 04/28/22 at 1:28pm revealed: -She was no longer working at the facility. -The medication aides (MA) were responsible to complete the controlled substance return form supplied by the facility's contracted pharmacy and keep a copy when returning controlled medications. -She kept some of the CSCS documents in her office. -She did not have a system in place to audit return of controlled substances. -She had implemented the corporate controlled substance tracking which no longer used the CSCS provided by the facility's contracted pharmacy but used a hardbound narcotic inventory book.	D 392		

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D 392	Continued From page 74 -If the return documentation for Resident #3's lorazepam 0.5mg was not in the pharmacy invoice binder, she did not know where the credit would be located. Interview with a second shift medication aide (MA) on 04/28/22 at 4:00pm revealed: -Resident #3 only had 30 lorazepam 0.5mg dispensed on 03/07/22 available for administration. -Resident #3 did not have overstock lorazepam 0.5mg that she was aware of. -The MAs counted narcotics between shifts or with medication cart keys pass-off. -She had not returned lorazepam 0.5mg for Resident #3 to the contracted pharmacy. Interview with a Supervisor/medication aide (S/MA) on 04/29/22 at 10:40am revealed: -The MAs counted narcotics between shifts. -All the controlled medications for Resident #3 were on the medication carts as far as she knew (no overstock). -The MAs were supposed to document any returned controlled substances on the return sheet provided by the facility's contracted pharmacy, keep a copy of the return form, and place the copy in the pharmacy invoice binder. -The HWD had been presented the MAs with a new corporate hardbound control substance inventory book before she resigned. -The HWD had moved a lot of the CSCS documentation to her office when she was working on the new book. -Any returned lorazepam 0.5mg for Resident #3 should have a copy of the return in the invoice binder. -She could not locate any return sheets for lorazepam 0.5mg for Resident #3. -She did not know where else there would be	D 392		

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D 392	Continued From page 75 documentation for the disposition of the 48 lorazepam 0.5mg tablets for Resident #3. Interview with the Administrator on 04/29/22 at 12:30pm revealed: -The HWD was responsible to ensure controlled substances were accounted for. -The return of controlled substances should be documented on the form provided by the facility's contracted pharmacy and kept in the invoice binder. -He was not aware the HWD was not auditing CSCS and inventory for accounting for the receipt, administration, and/or disposition of the controlled medication. -He was not aware there were 48 lorazepam 0.5mg tablets without proper accounting for Resident #3.	D 392		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.	D 612		

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D 612	Continued From page 76 This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to protect 41 residents in a special care unit during the global coronavirus (COVID-19) pandemic as related to the screening of residents. The findings are: Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for healthcare personnel during the coronavirus disease 2019 (COVID-19) pandemic dated 02/02/22 revealed: -Facilities should establish a process to identify anyone entering the facility, regardless of vaccination status, who has any one of the following three criteria so that they can be managed: a positive viral test for COVID-19, symptoms of COVID-19, or close contact with someone with COVID-19 infection. -The options could include (but were not limited to): individual screening upon arrival to the facility or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility. Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARs-CoV-2 spread in Nursing Homes dated 02/22/22 revealed residents should be evaluated daily for symptoms of COVID-19 and actively monitor residents for fever. Review of the North Carolina Department of	D 612		

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D 612	Continued From page 77 Health and Human Services COVID-19 Post Acute Care Setting Infection Control Assessment and Response (ICAR) tool dated 10/2021 revealed the staff and residents should be actively screened daily for fever, signs, and symptoms of COVID-19. Review of the facility's COVID-19 policies revealed: -There was a COVID-19 "playbook" that was last updated on 03/21/22. -There was documentation to utilize the screening log for residents (upon return from an outing, based on change of condition with symptoms and as the Director of Clinical Care Services directed), family, visitors, and associated or state specific screening log as indicated. -There was documentation associates should screen at the beginning of every shift and document in the screening log. Review of five residents' February 2022, March 2022, and April 2022 electronic medication administration records (eMARs) revealed there was no documentation of daily temperatures. Interview with a Medication Aide (MA) on 04/28/22 at 11:11am revealed: -Resident's temperatures were checked monthly when vital were taken. -They would check a resident's temperature if the resident was showing signs of COVID-19. -She did not recall the last time the residents' temperatures were checked more often than monthly. -She did not know why they stopped checking the residents' temperatures more often than monthly. Interview with another MA on 04/28/22 at 12:01pm revealed:	D 612		

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D 612	Continued From page 78 -When there was COVID-19 in the facility, they checked the residents' temperatures every day. -The previous Health and Wellness Coordinator gave her a sheet every day when she worked to check the residents' temperatures. -When there was no COVID-19 in the facility the HWC stopped providing the sheet for daily temperatures. -She knew they were still taking daily temperatures this year (since January 2022) but she could not recall when it stopped. Interview the facility's contracted Register Nurse (RN) on 04/26/22 at 11:32am revealed: -She had been working at the facility since late March 2022. -She did not know what the CDC recommended for resident temperature checks. -If a resident was symptomatic the resident was checked with a COVID-19 test. -They had an employee who tested positive last week so all the residents were tested on two different days for COVID-19; all were negative. -The district team updated the Administrator about CDC guidelines and protocols related to COVID-19. Interview with the Administrator on 04/28/22 at 1:42pm revealed: -Information related to COVID-19 came from district leadership. -Any changes from the state or if there were positive COVID-19 cases in the facility, the district leadership would direct them on what to do. -Residents' temperatures were only checked if they exhibited signs and symptoms of COVID-19; unusual coughing, appeared to not feel well, or any changes noted by staff. -He did not know when the resident's daily temperature checks were stopped.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING _____ B. WING _____	R 04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

(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 612	Continued From page 79 -He did not know the current guidelines were to check the resident's temperatures daily.	D 612		
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 ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision and health care. The findings are: 1. Based on interviews and record review the facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#2) who sustained 8 falls in 8 weeks, one of which resulted in an injury. [Refer to Tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 2 of 5 sampled residents (#1, #2) as evidenced by the failure to have staples removed from a scalp laceration (#2); and a referral for a resident with orders for physical therapy and Home Health skilled nursing and to apply ice to a	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

(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
D912	Continued From page 80 surgical site to reduce swelling (#1). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		

The following is a summary of the Plan of Correction for Brookdale High Point North Memory Care. This Plan of Correction is in regards to the Corrective Action Report dates April 29, 2022. This Plan of Correction is not to be constructed as an admission of or agreement with the findings and conclusions in the State of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation, nor have we identified mitigating factors.

10A NCAC 13F .0901(b) Personal Care and Supervision

(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

- The Health & Wellness Director/Nurse/Executive Director or designee will conduct an audit on all current residents care plans with assessed needs to verify personal care and supervision provided based on the resident's care plan. Current associates will be retrained by the Health & Wellness Director/Nurse/Executive Director or designee on resident specific assignment sheets and care plans. To assist with ongoing compliance, the Health & Wellness Director/Nurse/Executive Director or designee will review resident care plans once weekly for 6 weeks. Plan of correction to be completed by June 13, 2022.

10A NCAC 13F .0902(b) Health Care

The facility shall assure referral and follow-up to meet the routine and acute health care needs of the residents.

- The Health & Wellness Director/Nurse/Executive Director or designee will conduct retraining for all care associates on referral and follow up of physician's orders. The Health & Wellness Director/Nurse/Executive Director or designee will conduct an audit on all current resident records to verify that physician orders are being followed as ordered. To assist with ongoing compliance, the Health & Wellness Director/Nurse/Executive Director or designee will provide weekly monitoring of physician orders for three (3) months, with the Health & Wellness Director/designee to monitor routinely thereafter. Plan of correction to be completed by June 13, 2022.

10A NCAC 13F .0904(e)(4) 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.

- The Health & Wellness Director/Nurse/Executive Director or designee will conduct an audit on all current residents prescribed diet orders to verify the Dining Services Manager and dining staff have the current physician ordered diet. The Health & Wellness Director/Nurse/Executive Director/designee and/or Dining Services Manager will provide retraining on diets for all associates who serve resident meals. To assist with ongoing compliance, the Health & Wellness Director/Nurse/Executive Director or designee will review resident diets weekly for 6 weeks. Plan of correction to be completed by June 13, 2022.

10A NCAC 13F. 1004 Medication Administration

An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

- The Health & Wellness Director/Nurse/Executive Director or designee will rein-service medication aids & LPN's on the 7 rights of medication administration, to be completed by June 13, 2022. The Health & Wellness Director/Nurse/Executive Director or designee will review the New Order Tracking forms to verify accuracy and transcription of physician orders twice weekly for 6 weeks. Plan of correction to be completed by June 13, 2022.

10A NCAC 13F .1008(a) Controlled Substances

(a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.

- The Health & Wellness Director/Nurse/Executive Director or designee will rein-service medication aids & LPN's on the controlled substance policy, to be completed by June 13, 2022. To assist with ongoing compliance, the Health & Wellness Director/Nurse/Executive Director or designee will review the controlled substance log book along with the pharmacy delivery/return

to pharmacy forms twice weekly for 6 weeks. Plan of correction to be completed by June 13, 2022.

10A NCAC 13F .1801(c) Infection prevention and control program (temp)

- The Health & Wellness Director/Nurse/Executive Director or designee will retrain all clinical staff on daily temperature checks for the residents and documentation of results. To assist with ongoing compliance, the Health & Wellness Director/Nurse/Executive Director or designee will audit documentation of daily temperature checks 3 times weekly for 3 weeks. Plan of correction to be completed by June 13, 2022.

G.S. 131D-21(2) 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.

- The Health & Wellness Director/Nurse/Executive Director or designee will rein-service all associates of the Declaration of Resident's Rights, to be completed by June 13, 2022. The Health & Wellness Director/Nurse/Executive Director or designee will provide staff retraining monthly for 6 months on the Deceleration of Residents' Rights. Plan of correction to be completed by June 13, 2022.

Ryan Smith
Executive Director

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

Certified Mail and Electronic Mail
 # 7021 0950 0000 9786 5467

May 10, 2022

Ms. Lucinda Baier, President and Chief Executive Officer
Southern Assisted Living, LLC, Licensee
Brookdale High Point North
1564 Skeet Club Road
Greensboro, N.C. 27265

E-mailed: cstrasburg@brookdale.com
rsmith125@brookdale.com

Re: Annual and Follow-up Survey completed April 29, 2022 (ASPEN Event ID:J18511)
Type B Violations

Facility:	**Brookdale High Point North**
Licensure Number:	**HAL-041-033**
County:	**Guilford**

Dear Ms. Baier:

Thank you for the cooperation and courtesy extended during the survey completed April 29, 2022 by staff with the Adult Care Licensure Section.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

Type B Violations

- Type B rule violations are cited for **10A NCAC 13F .0901(b) Personal Care and Supervision, 10A NCAC 13F .0902(b) Health Care** and **G.S. § 131D-21 Resident Rights.**
- Type B Violations must be corrected within 45 days from the exit date of the survey, which is **June 13, 2022.**

As set forth in G.S. § 131D-34 where a facility has failed to correct a Type B Violation, the Department shall assess the facility a civil penalty in the amount of up to $400.00 for each day that the violation continues beyond the time specified for correction.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again
- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form within 15 working days from the date of receipt of this letter. 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.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **June 01, 2022.** An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by **June 01, 2022**. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at (336) 341-8127. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

Sincerely,

H Ray Peedin, RPh

H. Ray Peedin, Registered Pharmacist
Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies
Revisit Report

cc: Ms. Ursula Harris, Supervisor/Designee, Guilford County Department of Social Services
Mr. Ryan Smith, Executive Director w/enclosures (included in certified #7021 0950 0000 9786 5467)
Ms. Carolyn Harrison, Team Supervisor, Central Region, Adult Care Licensure Section
Facility File

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, Division of Health Service Regulation, at 919-855-3750.

Customer Service Survey web site: **http://info.ncdhhs.gov/dhsr/customerservice.html**
(Survey Max does not work well with all browsers, please access survey with Internet Explorer)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER HAL041033 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT 4/29/2022 (Y3)
NAME OF FACILITY BROOKDALE HIGH POINT NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 SKEET CLUB ROAD HIGH POINT, NC 27265	

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0074 Reg. # 10A NCAC 13F .0306(a)(1) LSC	Correction Completed 10/31/2018	ID Prefix D0282 Reg. # 10A NCAC 13F .0904(a)(1) LSC	Correction Completed 10/31/2018	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR [signature]	DATE 04/29/22
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/31/2018	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			