

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE NEW BERN		STREET ADDRESS, CITY, STATE, ZIP CODE 1336 SOUTH GLENBURNIE ROAD NEW BERN, NC 28562		
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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey December 10-11, 2015 and December 14-15, 2015.	{D 000}		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes;	D 255		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

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D 255	Continued From page 1 (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure an assessment was completed within 10 days following a change of condition for 2 of 2 residents sampled (#1, #3) with significant changes in their ability to walk and transfer. The findings are: 1. Review of Resident #1's current FL-2 and FL-2 addendum dated 04/27/15 revealed: - Diagnoses included coronary artery disease (CAD), cardiomyopathy, atrial fibrillation with pacemaker placement, Stage III chronic kidney disease, mild cognitive impairment, and history of cerebrovascular accident (CVA). - Resident #1 was intermittently disoriented. - Resident #1 was ambulatory. Review of the Resident Register revealed Resident #1 was admitted to the facility on 04/26/15. Observation and interview with Resident #1 on 12/10/15 at 11:42 am revealed: - Resident #1 was alert and oriented.	D 255		

Division of Health Service Regulation

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D 255	Continued From page 2 - Resident #1 was sitting in a wheelchair in the bedroom area of his room. - There was a walker between the sofa and recliner in the sitting area of the room. - Resident #1 had fallen "over and over" and was receiving physical therapy (PT). Observation and interview with Resident #1 on 12/11/15 at 3:00 pm revealed: - Resident #1 was sitting in the recliner in his room with his legs and feet propped up by his wheelchair. - Resident #1 was alert and oriented - He was supposed to use the call bell to let staff know when he needed help transferring, but "I do it (transfer) by myself" because "when I call them they don't necessarily come." Observation of Resident #1 on 12/11/15 at 5:00pm revealed: - Resident #1 was in the recliner in his room. - Resident #1 attempted to stand up and transfer from the recliner to his wheelchair (the wheels were not locked on the wheelchair). - Resident #1 fell into his wheelchair twice when attempting to pull himself up with the arms of the unlocked wheelchair - The surveyor pulled the call bell cord and the staff answered the call by using the intercom system. - Resident #1 told the staff (via the intercom) he was having trouble getting in his wheelchair. Observation on 12/11/15 at 5:05pm revealed a staff member came into Resident #1's room and assisted him to transfer into the wheelchair and rolled him out of the room up the hallway towards the dining room. Interview with the staff member on 12/11/15 at	D 255		

Division of Health Service Regulation

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D 255	Continued From page 3 5:12pm revealed: - Resident #1 required assistance with transferring "when he calls." - "Sometimes" Resident #1 did not call staff for assistance. - "If I am not mistaken, they just did an assessment of him and he requires assistance with transfer." Confidential staff interview revealed: - Resident #1 had multiple falls beginning "3 or 4 months ago." - When Resident #1 first moved in to the facility, he was independent with transfers and walking with his walker. - Resident #1 "really started declining" in October 2015 and kept falling when trying to go to the bathroom. - Resident #3 was not supposed to get up or walk without calling staff for assistance because he had a history of multiple falls. Review of Resident #1's record review revealed: - A physician's order for PT evaluation and treatment dated 10/12/15. - A physician's order for a wheelchair dated 11/02/15. - A physician's order for assistance with transfer dated 12/09/15. Review of Resident #1's "Personal Service Plan" (PSP) assessment and care plan (CP) dated 05/14/15 revealed: - Resident #1 was independent with transferring. - Resident #1 used a walker but was "independent going to and from the dining room or community activities." - There was no documentation that Resident #1 had fallen.	D 255		

Division of Health Service Regulation

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D 255	Continued From page 4 - The PSP/CP was signed by the Registered Nurse/Health and Wellness Director (HWD) and dated 05/14/15. - The PSP/CP was not signed by Resident #1's POA. - The PSP/CP was signed by the physician and dated 06/09/15. Review of Resident #1's most current PSP/CP dated 11/09/15 revealed: - Resident #1 required extensive assistance with ambulation. - Resident #1 was independent with transferring. - The PSP/CP was signed by the HWD and dated 11/18/15. - The PSP/CP was not signed by the POA. - The PSP/CP was signed by the physician and dated 11/20/15. Interview with the contracted Physical Therapist on 12/11/15 at 9:20am revealed: - Resident #1 began physical therapy (PT) on 10/14/15 due to multiple falls in a two months. - Resident #1 fell "3 or 4 times" after PT was initiated in October 2015. - Resident #1 had been able to transfer and use his walker independently before he began PT. - Resident #1 required assistance with transferring and use of his walker. Telephone interview with Resident #1's family member/Power of Attorney (POA) on 12/11/15 at 12:39pm revealed: - Resident #1 was "prone to falls." - Resident #1 had "broken ribs about two months ago" as the result of a fall at the facility. - Resident #1 was able to get out of bed and use his walker independently to ambulate until	D 255		

Division of Health Service Regulation

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D 255	Continued From page 5 "sometime in early October" (2015). - Resident #1 currently needed help with transferring to prevent him from falling. - "So far he has not received the care he needs to prevent him from falling but we [the POA and the HWD] changed his care plan just last month" (November 2015). Review of the "Resident Log" for Resident #1 revealed documentation by the HWD dated 11/20/15 which included: "Discussed care needs with resident and [POA]. Care plan increased..." Interview with the HWD on 12/14/15 at 4:55pm revealed she was responsible for completing resident assessments and PSP/CPs. Interview with the HWD on 12/15/15 at 10:55am revealed: - She did not know why Resident #1's PSP/CP was not updated when he had a change in condition. - She "maybe" wanted to talk to [Resident #1's POA]. - Resident #1's PSP/CP had not been updated until she talked with his POA sometime in November (2015) and increased his care plan. Interview with the Executive Director (ED) on 12/11/15 at 11:40am revealed an increase in a resident's care plan meant there would be an additional cost to the resident for the increased level of care. Refer to the interview with the Resident Care Coordinator (RCC) on 12/15/15 at 1:00pm. Refer to the interview with the ED on 12/14/15 at 11:10am.	D 255		

Division of Health Service Regulation

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D 255	Continued From page 6 Refer to the interview with the ED on 12/15/15 at 11:50am. Refer to the interview with the Regional RN on 12/15/15 at 11:55am. 2. Review of Resident #3's current FL-2 dated 04/24/15 revealed: - Diagnoses included encephalopathy, acute on chronic atrial fibrillation, cardiomyopathy, and advanced dementia. - Resident #3 was ambulatory. - Resident #3 was intermittently confused. Review of the Resident Register revealed Resident #3 was admitted to the facility on 04/24/15. Observation and interview with Resident #3 on 12/10/15 at 10:59am revealed: - Resident #3 was in her room with her husband. - She was alert to self; she was not oriented to time, place, and situation. - There were 2 walkers and 1 wheelchair in the living room area of Resident #3's room. - Resident #3 did not know who the walkers or wheelchair belonged to. - Resident #3's husband stated "she keeps falling." - Resident #3 did not remember falling; "I'll be darned if I can remember that. I don't think he is right. I did not fall." - Resident #3 got off of her bed and walked without her walker out the door of her room into the hallway. - Resident #3 had an unsteady gait when getting up off the bed and walking. - Resident #3's husband was prompting her to use her walker and she ignored his prompts.	D 255		

Division of Health Service Regulation

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D 255	Continued From page 7 Observation of Resident #3 on 12/15/15 at 10:41am revealed: - She was in her room with her husband and Powers Of Attorney (POAs) present. - She was not oriented to time, place, and situation. - Resident #3 required 7 prompts from her POAs and husband to use her walker within a time period of less than 10 minutes. - Resident #3 had an unsteady gait. Confidential staff interview revealed: - Resident #3 began falling "2 months or so ago." - Resident #3 had been found by a "night Medication Aide" outside without any clothes on and she did not have her walker. - The staff was concerned because Resident #3 was falling and not using her walker; the staff member talked to the HWD about her concerns. - The HWD told the staff to "fax the doctor ...that is all she done." - Resident #3 needed someone to remind her to use her walker and "she still forgets." Confidential interview with a second staff member revealed: - Resident #3 "won't use her walker." - In "September or October maybe" Resident #3 was more confused and started having multiple falls. - At times, Resident #3 was so confused that she did not know she had a walker or which walker was hers. - Resident #3's husband or staff had to constantly remind her to use her walker so she did not fall. - Resident #3 was "shaky" on her feet and was not supposed to walk without her walker.	D 255		

Division of Health Service Regulation

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D 255	Continued From page 8 - When Resident #3 first moved into the facility, she was able to use her walker without assistance with "very little reminders from [her husband]" and was not falling. Interview with the contracted Physical Therapist on 12/11/15 at 9:20am revealed: - Resident #3 had a history of falls and received physical therapy (PT) from 10/16/15 through 11/13/15. - Resident #3 could not use her walker independently because she needed verbal prompts due to her dementia. Interview with Resident #3 family members (POAs) on 12/14/15 at 1:00pm revealed: - Resident #3 started falling in "August or September." - She had "8 falls in 1 week within the last 4 weeks." - She had been injured as a result of her falls. - Resident #3 is "unsteady on her feet" and is not supposed to be walking without her walker and staff prompting assistance. - Resident #3 forgets to use her walker unless "someone is right there with her." Review of the Licensed Health Professional Support (LHPS) reviews for Resident #3 revealed: - The LHPS Review signed by the HWD and dated 08/11/15 revealed "none" LHPS personal care tasks were provided to Resident #3. - The LHPS Review signed by the HWD and dated 10/01/15 revealed Resident #3 required physical assistance with her walker when ambulating. Review of the Progress Note dated 10/19/15 and electronically signed by Resident #3's Primary	D 255		

Division of Health Service Regulation

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D 255	Continued From page 9 Care Physician (PCP) revealed: - Resident was evaluated by the PCP after having a fall the previous week. - She had "ecchymosis (bruising) and a laceration that did not require stitches" as a result of the fall. - She had "severe dementia." - "I tried to communicate with her today in the office and explain to her that she is not to get up and ambulate without the help of a walker with assistance ..." Review of Resident #3's "Personal Service Plan" (PSP) assessment and care plan (CP) dated 05/11/15 revealed: - "Resident is oriented to person, place, and time." - "Forgetful, progressive dementia, functions well with husband." - Resident #3 was independent with ambulation, transferring, and toileting. - The PSP/CP was signed by the HWD and dated 05/15/15. - The PSP/CP was signed by the POA and dated 05/15/15. - The PSP/CP did not contain the signature of Resident #3's PCP. Review of Resident #3's PSP/CP dated 11/24/15 revealed: - "Resident is oriented to person, place, and time." - "Forgetful, progressive dementia, functions well with husband." - "Resident is independent going to and from the dining room or community activities." - The PSP/CP was not signed by the HWD, PCP, or POAs. Interview with the HWD on 12/14/15 at 4:55pm	D 255		

Division of Health Service Regulation

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D 255	Continued From page 10 revealed: - She was responsible for completing resident assessments and PSP/CPs. - If she [the HWD] documented Resident #3 was alert and oriented times three on her PCP/CP dated 05/11/15 "then that is what she was when I assessed her." - Resident #3 had not been alert to person, place, and time on 11/24/15; the HWD was "unsure how that got on there. That's really weird " because she just answers the questions about the resident by clicking on the correct answer. - Resident #3 could not ambulate independently on 11/24/15 and had required assistance with prompting to use her walker since October (2015). - The HWD was "not sure" why Resident #3's PSP/CP was not updated before 11/24/15 because she had a significant change in her condition. Interview with the Executive Director (ED) on 12/15/15 at 11:55am revealed Resident #3's PSP/CP dated 11/24/15 was not right because Resident #3 was confused and was not independent going about the community on 11/24/15. Interview with the ED on 12/15/15 at 2:55pm revealed: - The HWD had just finished completing another PSP/CP for Resident #3. - The ED provided a copy of the new PSP/CP for Resident #3 dated 12/14/15. Review of Resident #3's PSP/CP dated 12/14/15 revealed: - Resident #3 was not always oriented to place and time - "Provide staff attention and/or verbal prompts	D 255		

Division of Health Service Regulation

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D 255	Continued From page 11 to and from the dining room and/or community." - The PSP/CP was signed by the HWD and dated 12/14/15. - The PCP/CP was not signed by the PCP or POAs. Interview with the Regional RN on 12/15/15 at 10:30am revealed: - Alert and oriented times three (person, place, and time) is an option in the facility's system which must be chosen by the operator of the system. - Since Resident #3 was not alert and oriented to person, place, and time on 11/24/15 it must have been "operator error." Refer to the interview with the Resident Care Coordinator on 12/15/15 at 1:00pm. Refer to the interview with the ED on 12/14/15 at 11:10am. Refer to the interview with the ED on 12/15/15 at 11:50am. Refer to the interview with the Regional RN on 12/15/15 at 11:55am. _____ Interview with the Resident Care Coordinator (RCC) on 12/15/15 at 1:00pm revealed: - The HWD was responsible for completing resident Care plans. - The RCC did not know how often the HWD updated each resident's care plan. - Care Plans were in each resident's record. - The daily task sheets were generated and printed care and interventions for each resident. - The changes were communicated to staff by	D 255			

Division of Health Service Regulation

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D 255	Continued From page 12 reviewing the care plan or memos from the HWD. Interview with the ED on 12/14/15 at 11:10am revealed Resident #1 and Resident #3's PSP/CPs had not been updated per the facility policy because the HWD "did not understand what that meant." Interview with the ED on 12/15/15 at 11:50am revealed: - The HWD was expected to complete and update resident PSP/CP's according to the facility policy and state rules. - Resident #1 and Resident #3's PSP/CP were not updated within 10 days of the significant change in their condition. Interview with the facility's Regional RN on 12/15/15 at 11:55am revealed the changes in Resident #1 and Resident #3's condition were not "acute episodes" but significant changes which required an updated assessment and PSP/CP.	D 255		
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 A1 VIOLATION Based on observations, record reviews and interviews, the facility failed to provide supervision	D 270		

Division of Health Service Regulation

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D 270	Continued From page 13 in accordance with each resident's assessed needs, care plan, and current symptoms for 3 of 5 residents (#1, #3, #4) sampled with multiple falls, including falls resulting in head injuries, sutures, pneumothorax, broken rib, bruising, and skin tears. The findings are: Review of the facility's "Fall Management Program" policy dated "October 2013" revealed: - "The Fall Management Policy consists of the following components: education, evaluation, interventions, post fall interventions, and quality performance improvement." - "Education: Associates receive education regarding seniors and fall during their orientation process and annually thereafter." - "Evaluation: A Risk Identification Evaluation is completed for each resident upon move-in, upon change of condition and every six months thereafter." - "Interventions: Residents who have falls risks identified will have individualized interventions included in their Personal Service Plans." - "Post Fall Investigations: Following a fall, the associates complete the Post Fall Investigation to determine if the resident's fall risks have changed and/or if interventions need to be updated." - "Quality Performance Improvement: Falls are tracked and trended each month at the community and opportunities for improvement are discussed during the Collaborative Care Review." 1. Review of Resident #3's current FL-2 dated 04/24/15 revealed: - Diagnoses included encephalopathy, acute on chronic atrial fibrillation, cardiomyopathy, history of lymphoma, and advanced dementia. - Resident #3 was ambulatory.	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 270	Continued From page 14 - Resident #3 was intermittently confused. Review of the Resident Register revealed Resident #3 was admitted to the facility on 04/24/15. Review of Resident #3's "Personal Service Plan" (PSP) assessment and care plan (CP) dated 05/11/15 revealed: - "Resident is oriented to person, place, and time." - "Forgetful, progressive dementia, functions well with husband." - Resident #3 was independent with ambulation, transferring, and toileting. - There were no fall interventions documented on the PSP. Review of Resident #3's PSP/CP dated 11/24/15 revealed: - "Resident is oriented to person, place, and time." - "Forgetful, progressive dementia, functions well with husband." - Resident #3 had fallen with harm or injury requiring emergency room treatment. - "Consider request for further evaluation by Primary Care Provider (PCP) ..." - "Consider involvement of Physical and/or Occupational Therapy ..." - "Encourage program participation as means to increase observation." - "Be alert to heightened risk for falling." Interview with the Executive Director (ED) on 12/15/15 at 11:55am Resident #3's PSP/CP dated 11/24/15 was not correct because Resident # 3 was confused and was not independent going about the community on 11/24/15 .	D 270		

Division of Health Service Regulation

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D 270	Continued From page 15 Interview with the ED on 12/15/15 at 2:55pm revealed: - The Health and Wellness Director (HWD) had just finished completing another PSP/CP for Resident #3. - The ED provided a copy of the new PSP/CP for Resident #3. Review of Resident #3's PSP/CP dated 12/14/15 revealed: - Resident #3 was not always oriented to place and time. - Resident #3 had fallen with harm or injury requiring emergency room treatment. - "Consider request for further evaluation by Primary Care Provider (PCP) ..." - "Consider involvement of Physical and/or Occupational Therapy ..." - "Encourage program participation as means to increase observation." - "Provide staff attention and/or verbal prompts to and from the dining room and/or community." - "Be alert to heightened risk for falling." - The PSP/CP was signed by the HWD and dated 12/14/15. Review of the Risk Identification Evaluation revealed: - The only Risk Identification Evaluation completed for Resident #3 was dated 09/24/15 and signed by the HWD. - The Risk Identification Evaluation dated 09/24/15 included documentation that Resident #3 had fallen within the past 12 months which caused injury; she used an assistive device; she appeared unsteady when ambulating "at times if doesn't use walker"; had vision deficits; had hearing deficits; and had decreased safety awareness. - There were no other Risk Identification	D 270			

Division of Health Service Regulation

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D 270	Continued From page 16 Evaluations found in Resident #3's record. Interview with the Health and Wellness Director (HWD) on 12/10/15 at 11:58am revealed: - Resident #3 had a recent history of multiple falls. - Resident #3 fell "7 or 8 times in a few days." Review of the "Progress Notes" from Resident #3's PCP revealed: - 09/25/15: Resident #3 was evaluated for follow up to a fall; a suture was removed from a laceration above her right eye; she was prescribed antibiotics for "cellulitis" in her right leg. - 10/09/15: Resident #3 was evaluated for multiple falls and confusion; "she continues to be extremely high risk for falls." Review of the hospital discharge summary dated 10/17/15 revealed diagnoses included "injury of unspecified body region, unspecified fall, and unspecified head injury." Review of the hospital discharge summary dated 11/22/15 revealed diagnoses included "fall" and "unspecified injury of head." Review of the hospital patient discharge instructions dated 11/24/15 revealed Resident #3 was evaluated for "dementia and multiple falls." Review of the Resident Log (RL) and Shift Reports (SR) revealed Resident #3 had a history of multiple falls on the following occasions: - RL on 09/18/15 at 7:00am: Resident #3 called staff to tell them she had fallen the night before; "she nor her husband could tell us when she fell or where she was found in her bed with a big mark on the left side of her face and eye.	D 270		

Division of Health Service Regulation

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D 270	Continued From page 17 Her face was bleeding and she had sores on both of her legs that was [sic] bleeding called 911." - RL 10/09/15 at 10:20am: "PCP (primary care provider) notified of increased confusion and 2 falls in the past month via fax. Awaiting response." - RL on 10/18/15 at 06:00am: "Resident does not remember her fall but I found her again outside in the courtyard with just a top on ... " Resident #3 did not have her walker. - RL on 11/13/15 at 10:30am: Resident was found in her room on the floor with no apparent injuries. - RL on 11/22/15 at 1:30pm: Resident #3 "had fall"; she was confused and "keep [sic] losing her balance when standing ..." - RL on 11/22/15 at 2:30pm: Resident #3 was found on the hallway floor with "two knots on her forehead" and was sent to the hospital for further evaluation. - RL on 11/23/15 at 06:15am: Resident #3 was found on the floor in her room with no apparent injuries; Resident #3 was "unaware" how she fell. - RL on 11/23/15 at 11:00am: Resident #3 "had another fall" in the living room area; the physician had been notified and the facility was awaiting a response form the physician. - RL on 11/23/15 at 7:00pm: "Resident is sitting with a Med Tech upon my arrival staff keeping a very close eye on resident because of multiple falls." - SR on 11/23/15 7:00am-7:00pm: Resident #3 fell two times and was sent to the hospital emergency department (ED). - RL on 11/24/15 at 12:05am: Staff went to check on Resident #3 and found her on the floor. - SR on 11/24/15 7:00pm-7:00am: Resident #3 had five falls during the shift and was sent to ED.; "continues to be very off balance. Continuous falls."	D 270		

Division of Health Service Regulation

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D 270	Continued From page 18 - RL on 12/13/15 at 5:00pm: Resident #3 told staff she tripped and landed on her husband and "messed up a lamp shade." - RL on 12/14/15 at 2:00am: Resident #3's husband called staff and said she fell off of the bed and requested assistance in getting her off of the floor; staff found her beside the bed on her knees. Review of the Post -Fall Investigation Reports revealed: - 10/17/15: Resident #3 was not using her walker and fell; safety interventions included reminding her to use her walker and referral to therapy for evaluation ambulation, gait, and mobility. - 11/22/15 at 1:30pm: Resident #3 was not using her walker or the call bell and fell in her bedroom; safety interventions included educate resident to use call bell, remind resident to use her walker and increase frequency of monitoring. - 11/22/15 at 2:30pm: Resident #3 was not using her walker and fell in the hallway; safety interventions included educate resident to use call bell, remind resident to use walker and handrails, and increase frequency of monitoring. Review of the Post -Fall Investigation Reports for Resident #3's five (5) falls on 11/23/15 revealed: - 06:15am: Resident #3 was "very confused"; safety interventions included educate resident to use call bell, remind resident to use walker, and increase supervision; "Secondary Evaluation: (to be completed by the Health and Wellness Director or the Executive Director)" included Resident #3 had recently returned from the hospital on 11/22/15 for a fall and "seems unsteady"; the Post -Fall Investigation Report was signed by the facility's Resident Care Coordinator (RCC).	D 270		

Division of Health Service Regulation

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D 270	Continued From page 19 - 0630am: Resident #3 was "very confused feeling around with hands"; Secondary Evaluation included Resident #3 was "unsteady"; safety interventions included educate resident to use call bell, remind resident to use walker, and increase supervision; the report was signed by the RCC. - 10:00am: Safety interventions included educate resident to use call bell, remind resident to use walker, and increase supervision; Secondary evaluation included Resident #3 was "weaker" and "went to ER and had a follow up appointment scheduled with her PCP; the report was signed by the RCC. - 10:30am: Safety interventions included educate resident to use call bell, remind resident to use walker, and increase supervision; secondary evaluation included Resident #3 had recently returned from the hospital on 11/22/15 for a fall; the report was signed by the RCC. - 6:30pm: Safety interventions included educate resident to use call bell, remind resident to use walker, and increase supervision; secondary evaluation included Resident #3 was "seen in ER today for fall"; the report was signed by the RCC. - No additional fall or safety interventions were documented on the Post-Fall Investigation Reports for 11/23/15. Confidential staff interview revealed: - Resident #3 was ordered physical therapy (PT) as an intervention for multiple falls. - The staff member was not sure of the date that Resident #3 started PT. - PT was usually the first intervention the facility implemented for residents with multiple falls - The staff member "kept her [Resident #3] with me once or twice to keep her from falling."	D 270		

Division of Health Service Regulation

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D 270	Continued From page 20 Review of the Fax Physician Order Sheet dated 10/09/15 revealed: - The Executive Director (ED) contacted Resident #3's PCP for "Resident is still having increased confusion and had had 2 falls in the past month. Please advise. Possible PT (physical therapy) eval (evaluation) and treat (treatment)?" - The PCP signed the form and wrote an order for physical therapy/occupational therapy (PT/OT) for Resident #3. Interview with the contracted Physical Therapist on 12/11/15 at 9:20am revealed: - Resident #3 had a history of falls and received physical therapy (PT) from 10/16/15 through 11/13/15. - Resident #3 could not use her walker independently because she needed verbal prompts due to her dementia. - The facility depended on Resident #3's husband "way too much" to provide prompts to her when she was ambulating with her walker. - The facility staff members the Physical Therapist had spoken with had not been able to report to her any individualized fall interventions for Residents #3. - The physical therapist had not observed any individualized fall or safety interventions for Resident #3. - The facility did not provide the interventions necessary for Resident #3 to transfer and ambulate safely. - She was unaware of staff providing increased supervision to Resident #3. - Resident #3 was "still unsafe" when she was discharged from PT services on 11/13/15 and she [the Physical Therapist] recommended that Resident # 3 receive a higher level of care and supervision.	D 270		

Division of Health Service Regulation

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D 270	Continued From page 21 The Physical Therapist told the Executive Director (ED) and a Medication Aide (MA) that Resident #3 was still unsafe after she completed PT and documented the information in Resident #3's record. - She had left a voicemail message for Resident #3's physician but had not received any additional orders from the physician. Review of the Resident Log dated 11/13/15 and signed by the Physical Therapist revealed Resident #3 was discharged from PT on 11/13/15 but was "still unsafe and doesn't follow instructions to use walker." Review of the electronic "Clinical Notes" from the contracted home health agency that provided PT service for Resident #3 revealed: - 10/19/15: "...had a fall Saturday because she was walking outside without her walker ..." - 11/03/15: "...patient still needs cues to walk into the walker and with walker at all times." - 11/09/15: "...after resting, [Resident #3] forgot we ambulated all together...said she didn't need her walker." - 11/13/15: "Patient does not use her walker in room and doesn't listen to husband [sic] suggestions ...improved balance, strength, and endurance but goal not met." Observation and interview with Resident #3 on 12/10/15 at 10:59am revealed: - Resident #3 was in her room with her husband. - She was alert to self; she was not oriented to time, place, and situation. - There were 2 walkers and 1 wheelchair in the living room area of Resident #3's room. - Resident #3 did not know who the walkers or wheelchair belonged to.	D 270		

Division of Health Service Regulation

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D 270	Continued From page 22 - Resident #3's husband stated "she keeps falling." - Resident #3 did not remember falling; "I'll be darned if I can remember that. I don't think he is right. I did not fall." - Resident #3 got off of her bed and walked without her walker out the door of her room into the hallway. - Resident #3 had an unsteady gait when getting up off the bed and walking. - Resident #3's husband was prompting her to use her walker and she ignored his prompts. Observation of Resident #3 on 12/15/15 at 10:41am revealed: - She was in her room with her husband and Powers Of Attorney (POAs) present. - She was not oriented to time, place, and situation. - She was alert to self and pleasantly confused. - Resident #3 required 7 prompts from her POAs and husband to use her walker within a time period of less than 10 minutes. - Resident #3 had an unsteady gait. Interview with Resident #3's family members/Powers of Attorney (POAs) on 12/14/15 at 1:00pm revealed: - She had "8 falls in 1 week within the last 4 weeks." - Her last fall was "last night" (12/14/15 at 2:00am). - She had been injured as a result of her falls. - Resident #3 had hit her head, bruised her face, "skinned" her legs, and needed sutures to her face as a result from her multiple falls - The facility notified the POAs if Resident #3 "has problems" such as falls. - Resident #3 had dementia that was "getting	D 270		

Division of Health Service Regulation

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D 270	Continued From page 23 worse" so she did not remember falling or being injured. - Resident #3 does not understand "where she is." - Resident #3 was "unsteady on her feet" and was not supposed to be walking without her walker. - Resident #3 forgot to use her walker unless "someone is right there with her." - The facility contacted the POAs that Resident #3 was outside of her room without her walker and clothes but the POAs were not notified she was actually outside of the building in the courtyard. - Resident #3's husband was her "caretaker even here" but he told the POAs he was scared Resident #3 is going to be seriously hurt because she will not "listen to him" and use her walker. - When Resident #3 started having multiple falls, the facility "got her therapy, tried to talk to her, and sometimes put her in her wheelchair near the office." - The POAs were overall happy with the care Resident #3 received at the facility. - The POAs had not been notified by the facility that Resident #3 was still unsafe after completing PT. - The facility notified the POAs that Resident #3 had 8 falls and was sent to the hospital twice; the POAs requested Resident #3 be evaluated by her PCP - The HWD had not spoken with the POAs until that date (12/14/15) about having Resident #3 evaluated for an increased level of care and supervision. Interview with the HWD on 12/14/15 at 4:55pm revealed: - The facility had a fall policy. - The HWD had a copy of the fall policy.	D 270		

Division of Health Service Regulation

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D 270	Continued From page 24 - She was responsible for completing the Risk Identification Evaluation and care plan for each resident in the facility. - The HWD acknowledged the Risk Identification Evaluation for Resident #3 had not been completed in accordance with the facility's fall policy (upon admission and significant change). - Resident #3 had been admitted to the facility around the same time the HWD was hired and she had "a lot" of training going on then so she was not there some days. - She was not sure why the Risk Identification Evaluation for Resident #3 was not completed until 09/24/15, which was after she had multiple falls and injury. - She may have completed a chart review for Resident #3 and noticed the evaluation was missing from her record. - There were no fall interventions in the facility's electronic system until "recently" which was why there were no fall interventions on Resident #3 's earlier care plans. - She thought the fall interventions had been added to the system in "maybe September or October" 2015. - Resident #3 had a urinary tract infection when she had the multiple falls from 11/22/15 through 11/24/15. - Staff had provided one on one supervision for Resident #3 by bringing her to the living room. - Resident #3 was "sitting with" the Medication Aide. - "They didn't chart anything. Staff said it was one on one." - The staff's charting "had a lot to be desired." - Resident #3's Primary Care Provider (PCP) had been notified by the facility of her multiple falls.	D 270			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 270	Continued From page 25 Confidential staff interview revealed: - Resident #3 "has had many falls. " - Resident #3 needed someone to remind her to use her walker and "she still forgets or won't listen sometimes." - Resident #3 had been found by a "night Medication Aide" outside without any clothes on and she did not have her walker two times in October 2015. - The staff was concerned about Resident #3 and talked to the HWD about her concerns. - The HWD told the staff to "fax the doctor ...that is all she done." - The staff member completed more frequent checks on Resident #3 "maybe every 30 minutes to 1 hour" due to her history of falls. - The staff member did not know if other staff members checked on Resident #3 more frequently. Confidential interview with a second staff member revealed: - Resident #3 "won't use her walker." - The staff member recalled Resident #3 being so confused that she did not know she had a walker or which walker was hers. - Resident #3 was "shaky" on her feet and was not supposed to walk without her walker. - The staff member could not recall any specific fall interventions being discussed during report or implemented for Resident #3. - The staff member knew from previous positions in other facilities to complete " more rounds " on residents at risk for falls. - The staff member recalled checking on Resident #3 " more often. " - Resident #3 had a history of multiple falls; "it went on for a while, then she was diagnosed with a UTI." - Without reviewing her record, the staff	D 270		

Division of Health Service Regulation

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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 270	Continued From page 26 member could not recall the date that Resident had 5 falls on one shift or 8 falls in two days. Review of the "Progress Notes" from Resident #3's PCP dated 11/27/15 revealed Resident #3 was evaluated for "several recent falls"; "Her dementia is worse and sometimes more confusion than they are accustomed to ...She may well have a urinary tract infection." Interview with the ED on 12/14/15 at 11:10am revealed: - The ED was not aware the Risk Identification Evaluation was not completed by the HWD for Resident #3 in accordance with the fall policy. - The ED did not know why the Risk Identification Evaluation had not been done in accordance with the facility's fall policy for Resident #3 (upon move-in). - The HWD had access to the facility 's fall policy. Interview with the ED on 12/15/15 at 11:15am revealed: - The ED had completed record reviews when the HWD was out on medical leave. - When completing record reviews, the ED noted several residents had multiple falls who had not had physical therapy (PT) recommended by the HWD so the ED notified each of the resident's physician's to request PT. - The ED expected the HWD to request PT for Resident #3. - The ED had personally requested PT for Residents #3 because it had not been done by the HWD. Interview with the Executive Director (ED) on 12/15/15 at 12:45pm revealed other than sitting with the Medication Aides some of the time to	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 270	Continued From page 27 increase supervision, the facility did not implement additional safety or fall prevention interventions for Resident #3 when she had the multiple falls from 11/22/15 through 11/24/15. Refer to 4 confidential staff interviews. Refer to interview with the Resident Care Coordinator (RCC) on 12/15/15 at 1:00pm. Refer to interview with the Health and Wellness Director (HWD) on 12/10/15 at 4:00 p.m. Refer to the Interview with the Regional RN on 12/15/15 at 10:30am. 2. Review of Resident #1's current FL-2 and FL-2 addendum dated 04/27/15 revealed: - Diagnoses included coronary artery disease (CAD), cardiomyopathy, atrial fibrillation with pacemaker placement, Stage III chronic kidney disease, mild cognitive impairment, benign prostate hyperplasia (BPH), history of cerebrovascular accident (CVA), and pre-diabetes. - Resident #1 was intermittently disoriented. - Resident #1 was ambulatory. Review of the Resident Register revealed Resident #1 was admitted to the facility on 04/26/15. Observation and interview with Resident #1 on 12/10/15 at 11:42 am revealed: - Resident #1 was dressed and neatly groomed. - Resident #1 was alert and oriented. - Resident #1 was sitting in a wheelchair in the bedroom area of his room - There was a walker between the sofa and	D 270		

Division of Health Service Regulation

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D 270	Continued From page 28 recliner in the sitting area of the room. - Resident #1 excused himself and went to the bathroom by shuffling his feet to move his wheelchair. - Resident #1 recalled falling "over and over." - Resident #1 received physical therapy (PT). - Resident #1 had fractured his ribs as a result of a fall "which hurt real bad." - Resident #1 had last fallen "Sunday" (12/06/15) and was sent to the hospital. - Resident #1 was "not significantly" injured from his fall on 12/06/15 but he was "sore." - Facility staff came "sometimes" when he rang his call bell. Observation and interview with Resident #1 on 12/11/15 at 3:00 pm revealed: - Resident #1 was sitting in the recliner in his room with his legs and feet propped up by his wheelchair. - Resident #1 was alert and oriented to person, place, and situation. - He had a "knot" on the back of his head from falling on 12/06/15. - He "fell against the bars in the in the shower" which resulted in "broken ribs." - Resident #1 did not know the date when he fractured his rib. - Resident #1 was still bothered with pain and being sore from the rib fracture. - Resident #1 did not receive assistance from facility staff with transferring to/from his bed, recliner, or wheelchair. - Resident #1 did not know how long he had been receiving PT or when he received his wheelchair. - He was supposed to use the call bell to let staff know when he needed help transferring, but "I do it (transfer) by myself" because "when I call them they don't necessarily come. I call them	D 270		

Division of Health Service Regulation

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D 270	Continued From page 29 before I get up and after I get in bed so they can monitor me." - Staff "occasionally" roll him in his wheelchair to the dining room. "I mainly do it myself." Observation of Resident #1 on 12/11/15 at 5:00pm revealed: - Resident #1 was in the recliner in his room. - Resident #1 attempted to stand up and transfer from the recliner to his wheelchair (the wheels were not locked on the wheelchair). - Resident #1 fell into his wheelchair twice when attempting to pull himself up with the arms of the unlocked wheelchair - The surveyor pulled the call bell cord and the staff answered the call by using the intercom system. - Resident #1 told the staff (via the intercom) he was having trouble getting in his wheelchair. Observation on 12/11/15 at 5:05 pm revealed a staff member came into Resident #1's room and assisted him to transfer into the wheelchair and rolled him out of the room up the hallway towards the dining room. Interview with a staff member on 12/11/15 at 5:12pm revealed: - The staff member was a cook but helped answer resident call bells. - Resident #1 required assistance with transferring "when he calls." - "Sometimes" Resident #1 did not call staff for assistance. - "If I am not mistaken, they just did an assessment of him and he requires assistance with transfer." Review of Resident #1's current Personal Service Plan/Care Plan (PCP/CP) dated 11/09/15	D 270		

Division of Health Service Regulation

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D 270	Continued From page 30 revealed: - Resident #1 required extensive assistance with ambulation and dressing. - Resident #1 was independent with transferring and toileting. - Resident #1 was oriented to person, place, and time. - Resident #1 had fallen within the past 12 months resulting in injury requiring ER evaluation and treatment. - Resident #1 used a mobility aid. - "Educate resident on the use of the emergency call system." - "Resident used physical therapy services in the past three months as of the date of this plan." Review of the Risk Identification Evaluation signed by the Health and Wellness Director and dated 09/24/15 revealed: - Resident #1 had fallen within the past 12 months; had vision and hearing deficits; used a walker; had a health conditions including cardiac dysrhythmia and history of stroke; and was prescribed anticoagulant and cardiac medications. - There were no other Risk Identification Evaluations found in Resident #1's record. Review of the "Fax Physicians Order Sheet" dated 10/09/15 revealed: - The Executive Director (ED) contacted Resident #1's Primary Care Provider by fax for request for referral for evaluation and treatment by physical therapy (PT). - "Resident has had 4 falls in past 2 months." - The form was signed by Resident #1's PCP and dated 10/12/15. Review of the "Resident Log" (RL) revealed Resident #1 had falls and/or injury on the	D 270			

Division of Health Service Regulation

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D 270	Continued From page 31 following occasions: - 09/29/15: "Resident pulled up on towel bar to get up & broke it & he fell on bathroom floor." - 10/28/15 at 5:30am: "Resident fell in his bathroom against metal bar." - 10/28/15 at 08:10am: Resident #1 was complaining of pain in his right arm, shoulder, neck and back. He asked staff to send him to the hospital to be evaluated. - 10/28/15 at 2:00am: He returned from the hospital with diagnosis including rib fracture. - 11/06/15: Resident #1 "was heard yelling" and told staff he had fallen and gotten himself into his recliner - 12/03/15: "Resident reported to staff that he had fallen backward in wheelchair and hit his head. He said he had been able to get himself up and pick up wheelchair. This is unlikely an actual fall due to resident's current health status." - 12/06/15: Resident #1 fell and was found on his bathroom floor. Review of the hospital discharge summary dated 10/28/15 revealed diagnoses included "fall, pneumothorax, and fracture of one rib." (Pneumothorax is a collapse of the lung). Review of the "Physician/Healthcare Provider Visit form" dated 10/29/15 revealed: - Resident #1 was evaluated for follow up to emergency room (ER) visit and diagnoses of right pneumothorax, right rib fracture, and right lower lobe atelectasis (Atelectasis is the collapse of the tiny air sacs of the lungs). - Resident #1 had decreased breath sounds throughout both of his lungs. - Resident #1 had right posterior flank pain. Review of the Shift Reports (SR) and RLs dated 10/28/15 from 7:00pm-7:00am through 10/31/15	D 270		

Division of Health Service Regulation

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D 270	Continued From page 32 from 7:00pm-7:00am revealed Resident #1 complained of pain each shift. Review of the SRs and RLs dated 11/01/15 through 11/05/15 revealed: - Resident #1 complained of pain 5 times - Resident #1 "can not [sic] get comfortable." - Resident #1 was "up and down every 10-15 minutes" due to "severe pain." Review of the hospital discharge instructions dated 12/06/15 revealed diagnoses included "unspecified fall, long term use of anticoagulants, and contusion of right elbow." Review of the "Physician/Healthcare Provider Visit form" dated 12/09/15 revealed: - Resident #1 was evaluated for follow up to an ER visit on 12/06/15. - A new physician order "Needs assistance with transferring." Confidential staff interview revealed: - Resident #1 had multiple falls beginning "3 or 4 months ago." - When Resident #1 first moved in to the facility, he was independent with transfers and walking with his walker. - He is not supposed to get up or walk without calling staff for help. - The staff recalled Resident #1 received PT but was not sure if he was still receiving PT at this time. Interview with the contracted Physical Therapist on 12/11/15 at 9:20am revealed: - Resident #1 began physical therapy (PT) on 10/14/15 due to multiple falls in a two month time frame. - Resident #1 fell "3 or 4 times" after PT was	D 270			

Division of Health Service Regulation

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D 270	Continued From page 33 initiated in October 2015. - Resident #1 had been able to transfer and use his walker independently before he began PT. - Resident #1 could not safely transfer or walk independently now. - Resident #1 required assistance with transfer and use of his walker. - Resident #1 had told the Physical Therapist he had gotten out of bed and into his wheelchair on that date (12/11/15) without assistance from staff. - Resident #1 told the Physical Therapist he "had to go" [to the bathroom] but staff did not answer his call bell quick enough so he went to the bathroom on his own. - Resident #1 had a call bell cord in his bathroom but he often did not use it because he needed "prompts" but did not get the prompts. - Staff did not provide the supervision Resident #1 required for safe transfer and ambulation. - The Physical Therapist had not observed staff assisting Resident #1 with transfers or providing more frequent supervision checks. - Because Resident #1 did not get the assistance he needed from facility staff "he does it" himself and it "takes a lot out of him." - PT had educated Resident #1, his family member, and facility staff fall interventions such as prompting him to ask for help with transferring and providing him with assistance to the bathroom. Review of the electronic "Clinical Notes" from the contracted home health agency provided PT service for Resident #1 revealed: - 10/17/15: "needed continued cues with ambulation because of short term memory loss." - 10/19/15: "patient still needs cue to walk into the walker."	D 270			

Division of Health Service Regulation

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D 270	Continued From page 34 - 10/22/15: "Patient needed cues for safe transfer from supine to sit. Patient reports when sitting he always loses his balance ... and can't control himself when sitting down." - 11/03/15: "patient ambulated with cues to walk into walker." Review of the Resident Log notes dated 10/30/15 revealed documentation by the contracted Physical Therapy provider which included "Patient fell and cracked a rib ...Physical Therapy Assistant assisted patient out of bathroom with son and talked about safety and fall prevention ...plan with staff to and from the bathroom. Requested facility to place an order for a wheelchair." Review of Resident #1's record revealed: - Resident #1 had multiple physician orders for Coumadin. (Coumadin is a medication that decreases the chance of blood clots forming in the body. Coumadin can cause bleeding which can sometimes lead to death). - Resident #1's most current physician order for Coumadin was dated 11/20/15 for Coumadin 5mg. every evening. - There was a physician order dated 11/02/15 for a wheelchair. Interview with the Resident Care Coordinator (RCC) on 12/15/15 at 1:00pm revealed: - The HWD was responsible for completing resident Care plans. - The RCC did not know how often the HWD updated each resident 's care plan. - Care Plans were in each resident 's record. - The daily task sheets were generated and printed care and interventions for each resident. - The changes were communicated to staff by reviewing the care plan or memos from the HWD.	D 270		

Division of Health Service Regulation

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D 270	Continued From page 35 Review of a typed "Memo" in the Staff Memo Book dated 12/11/15 revealed: - "Please escort [Resident #1] with walker to dining room. Follow with a wheelchair." - "He should not be ambulating on his own." - The "Memo" was not signed by the HWD. Review of a typed "Memo" in the Staff Memo Book dated 12/12/15 revealed: - "It was brought to my attention that there may be some confusion with the call bells." - "If we have a resident that uses the call bell, they are calling for assistance." - "Please provide that assistance to them." - "If a resident calls and says they are going to the bathroom, please go and help them." - The "Memo" was signed by the HWD. Telephone interview with Resident #1's family member/Power of Attorney (POA) on 12/11/15 at 12:39pm revealed: - Resident #1 had a history of multiple falls and was receiving PT. - Resident #1 had been injured with a "broken rib" as the result of a fall. - The facility notified the POA when Resident #1 fell and required further evaluation at the hospital. - Resident #1 was "constantly unbalanced" and complained of being dizzy "a lot." - The POA had been in frequent contact with the facility's Health and Wellness Director (HWD) in regards to Resident #1's falls and plan of care. - The facility had implemented interventions including physical therapy and encouraging Resident #1 to call for help to prevent him from falling. - The Health and Wellness Director (HWD) "says they need more money to increase his	D 270		

Division of Health Service Regulation

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D 270	Continued From page 36 care." - "So far he has not received the care he needs to prevent him from falling. We changed his care plan last month" (November 2015). - Resident #1 was supposed to receive assistance with transferring and ambulating after his care plan was changed. Review of the "Resident Log" dated 11/20/15 revealed: - "Discussed care needs with resident and [POA]. Care plan increased..." - The entry was signed by the HWD. Interview with the Health and Wellness Director (HWD) on 12/15/15 at 10:30am revealed she [the HWD] had not contacted Resident #1's PCP for referral to physical therapy after he had 4 falls in 2 months because "he was ambulatory and we were increasing his safety awareness as an intervention." Interview with the HWD on 12/14/15 at 4:55pm revealed: - The HWD acknowledged the Risk Identification Evaluation for Resident #1 had not been completed upon his admission to the facility or in accordance with the facility's fall policy. - She was not sure why the Risk Identification Evaluation for Resident #1 was not completed until 09/24/15, which was after he had multiple falls and continued to have falls after that date. - She may have completed a chart review for Resident #1 and noticed the evaluation was missing from his record. - There were no fall interventions in the facilities electronic system until "recently" which was why there were no fall interventions on Resident #1's care plan.	D 270		

Division of Health Service Regulation

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D 270	Continued From page 37 Interview with the ED on 12/14/15 at 11:10am revealed: - The ED was not aware the Risk Identification Evaluation was not completed by the HWD for Residents #1 in accordance with the fall policy. - The ED did not know why the Risk Identification Evaluation had not been done in accordance with the facility's fall policy for Resident #1 (upon move-in). Interview with the ED on 12/15/15 at 11:15am revealed: - The ED had completed record reviews when the HWD was out on medical leave. - When completing record reviews, the ED noted several residents had multiple falls who had not had physical therapy (PT) recommended by the HWD so the ED notified each of the resident's physician's to request PT. - The ED expected the HWD to request PT for Resident #1. - The ED had requested referral to PT for Resident #1 because it had not been done by the HWD. Interview with the Executive Director on 12/11/15 at 11:40am revealed: - Fall interventions implemented for Resident #1 included referral to physical therapy and notifying his physician. - An increase in a resident's care plan meant there would be an additional cost to the resident for the increased level of care. Refer to four confidential staff interviews. Refer to interview with the Resident Care Coordinator (RCC) on 12/15/15 at 1:00pm. Refer to interview with the Health and Wellness	D 270		

Division of Health Service Regulation

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D 270	Continued From page 38 Director (HWD) on 12/10/15 at 4:00 p.m. Refer to the Interview with the Regional RN on 12/15/15 at 10:30am. 3. Review of Resident #4's current FL-2 dated 12/04/15 revealed: - Diagnoses included atrial fibrillation, chronic venous insufficiency, peripheral vascular disease, elevated glucose, hypertension, hypothyroidism, edema, long-term anticoagulant therapy, gait disturbance, obesity, and knee pain. -Resident is semi-ambulatory and uses a walker and a wheelchair for assistance with ambulation. -Resident had an order for Xarelto 20mg every evening. (Xarelto is a blood thinner used to for stroke prevention in atrial fibrillation. Xarelto may increase the risk of bleeding.) Review of Resident #4's Resident Register revealed: - He was admitted to the facility on 11/17/14. - The resident needed assistance with dressing, bathing, ambulation, getting in and out of bed, toileting, skin care, and scheduling appointments. - The resident was forgetful and needed reminders. - The resident had a walker. Review of Resident #4's most recent assessment and care plan dated 08/05/15 revealed: - Resident needed limited assistance with dressing, bathing, toileting, and transferring. - Resident was independent with eating, ambulation, and grooming. - The resident required physical assistance with dressing and grooming related to balance and coordination issues. - It required 2 staff to assist the resident to a standing position from bed or chair.	D 270		

Division of Health Service Regulation

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D 270	Continued From page 39 - The resident was able to sit up with assistance of 2 persons using his lift chair. - He was able to stand/walk independently with walker after he was in standing position. Observation and interview of Resident #4 on 12/10/15 at 11:09 a.m. revealed: - Resident was sitting in lift chair with feet elevated and his walker was within reach. - Resident's call bell was within reach. - Resident stated, "I would walk you to the door if I could get up." - Resident reported he had "quite a few falls". - Resident was currently receiving physical therapy. Review of accident/incident reports, shift notes, and communication notes revealed Resident #4 had falls, bruises, or injuries on the following occasions: - 09/27/15 (1st shift) - Resident #4 had a fall. No apparent injuries noted by staff. - 10/01/15 (1st shift) - Resident #4 had a fall resulting in a skin tear to right arm. Resident reported that he was reaching for something and lost his balance. - 10/06/15 (1st shift) - Resident #4 found on floor in dining room. Resident reported that he lost his balance and fell over and hit the floor. Resident complained of back pain and was transported to the emergency room (ER). Family and Resident Care Coordinator (RCC) notified. - 10/09/15 (1st shift) - Resident #4 reported to the medication aide (MA) that "his back has been hurting him a lot the past few days". - 10/10/15 (1st shift) - Resident #4 complained of back pain to MA. MA noted that Resident #4 had a large bruise to his back. - 10/13/15 (2nd shift) - Resident #4 was found on floor in bathroom and reported hitting his head.	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 270	Continued From page 40 Noted that resident had a laceration to his head that was bleeding. Resident was transported to the ER. -10/14/15 (2nd shift) - Resident Assistant (RA) reported to Supervisor that resident had fallen. Resident was found standing in bathroom with head bleeding. Noted blood on bathroom floor and walls. Resident transported to ER. Family member and Executive Director notified of fall. -10/15/15 (1st shift) - Resident #4 had a fall. Resident was found in his room by RCC. RCC noted no serious injuries but resident did have scrapes on his right arm. -10/15/15 (2nd shift) - Resident #4 fell in his room. Resident found on floor in front of his bed with his head and shoulders under the bed. Resident was unable to move without yelling out in pain. Resident reported he hit his head and back on the footboard of his bed. Resident was transported to ER. -10/17/15 (1st shift) - Resident #4 was found on floor in front of bed on the night of 10/16/15. Resident reported that he was trying to go to the bathroom and fell. No injuries noted. Resident did complain of pain to back and buttocks. -10/27/15 (2nd shift) - Resident #4 fell in bathroom. No injuries noted. -10/28/15 (2nd shift) - Supervisor noted that Resident #4 left thigh was swollen and resident dragged left leg during ambulation. Resident complained of pain to left thigh when standing or walking. Physician was notified. -11/01/15 (1st shift) Resident #4 fell in bathroom. Resident reported that he lost his balance. No injuries noted. -11/07/15 (1st shift) - Resident #4 was found on the floor in his bathroom. Resident reported he had hit his head and staff noted a lump to resident's head after the fall. Resident was transported to ER.	D 270		

Division of Health Service Regulation

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D 270	Continued From page 41 -11/23/15 (2nd shift) - RA reported to Supervisor that resident had fallen while reaching for something. Resident did not voice any complaints or injuries. -11/27/15 (2nd shift) - Resident was found in floor in front of the door of his room. Resident stated that he was going to get some water and he fell over. No injuries reported. Review of Post-Fall Investigation forms for Resident #4 revealed: - 10/06/15 - Safety interventions included: Staff to educate resident on the use of their emergency call system; staff to remind resident to use assistive devices. - 10/13/15 - Safety interventions included: Staff to educate resident on the use of their emergency call system; staff to remind resident to use assistive devices; staff to call medical doctor for PT/OT evaluation. - 10/15/15 - Safety interventions included: Staff to educate resident on the use of their emergency call system; staff to remind resident to use assistive devices; increased frequency of monitoring; staff to call medical doctor to come see the resident. - 11/07/15 - Safety interventions included: Staff to educate resident on the use of their emergency call system; staff to remind resident to use assistive devices; increased frequency of monitoring; PT/OT evaluation Review of a primary care provider (PCP) note dated 10/16/15 revealed: - The chief complaint was urinary tract infection, status post fall. - The resident fell twice on same day on 10/14/15 with one fall resulting in head injury. - The resident stated he lost his footing, fell backwards and hit his head and back against the	D 270		

Division of Health Service Regulation

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D 270	Continued From page 42 wall. - PCP explained the importance of resident calling for assistance. - Physical therapy was ordered last visit and he has had one session so far. - PCP thoroughly discussed with staff regarding the importance of rounding and promptly responding to call lights. Interview with Resident Assistant (RA) on 12/11/15 at 9:05 a.m. revealed: - Staff usually does routine checks on residents every 2 hours to assist residents with their personal care needs. - RA stated that she had not been instructed to monitor Resident #4 more frequently due to his frequent falls. Interview with Resident #4 on 12/11/15 at 2:50 p.m. revealed: - He had fallen several times over the last few months. - When he falls he just loses his balance and falls over. - Resident uses a walker for assistance with ambulation. - He has a wheelchair but does not like to use it. - Resident had a lift chair in his room to assist him to stand and he was able to use the lift chair without assistance. - The lift chair was removed 12/10/15 and replaced with a recliner. - He was upset because his lift chair was taken away because the staff in the facility told his family it was a fall hazard. - He never had a fall using his lift chair - He was unable to get out of recliner without assistance. - Staff usually comes around about every 2 hours to check on him.	D 270			

Division of Health Service Regulation

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D 270	Continued From page 43 - He uses his call bell if he needs assistance. - It usually takes staff about 15 - 20 minutes to answer his call bell. Interview with Resident Assistant (RA) on 12/15/15 at 9:40 a.m. revealed: - Staff is available to help residents get up in the morning and staff checks on residents throughout the day. - RA voiced concerns regarding Resident #4's frequent falls. - Resident #4 falls a lot because the resident forgets to use the call bell to ask for help. - Resident #4's falls are mainly when the resident was trying to get to the bathroom. - Staff does incontinence checks every 2 hours for Resident #4. - Resident #4 does not like to get up early and does not usually get up for breakfast. - Staff offers the resident breakfast in his room. - Staff in the facility had received a memo communication from the HWD sometime after Thanksgiving instructing staff to keep the resident's lift chair unplugged unless staff was in the room providing care for the resident to prevent the resident from falling. Interview with Health and Wellness Director (HWD) on 12/15/15 at 12:15 p.m. revealed: - Resident #4 has a history of frequent falls. - The resident has had therapy after therapy for his falls. - He has decreased safety awareness. - He was not using the lift chair properly and could not demonstrate how to safely use to the HWD. - He would lean over and fall while reaching for things. - She was concerned for his safety and she spoke with his family and it was decided to unplug	D 270			

Division of Health Service Regulation

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D 270	Continued From page 44 the chair unless staff was in the room assisting the resident. - She thought if the chair was unplugged the staff could be there to supervise the resident during transfers and ambulation. - The resident did not like it when the chair was unplugged; he was so mad. - The goal was to get him to use his call bell. - The resident is currently getting physical therapy. - Staff routinely does 2 hour checks for residents. - She did not recall if supervision was increased for Resident #4 due to his falls. - She did not recall instructing staff to supervise the resident more frequently. Review of Resident #4's records revealed: - No documentation of any falls caused by the use of the lift chair. Interview with the Physical Therapist on 12/11/15 at 09:20 a.m. revealed: - The staff members she had spoken with had not been able to report to her any individualized fall interventions for Residents #4. - The only individualized intervention she was aware of was staff had unplugged Resident #4's lift chair (which was a "restraint"). - The facility does not provide the interventions needed for safe transfer and ambulation for Resident #4. Interview with Resident #4's primary physician's assistant (PA) on 12/15/15 at 1:17 p.m. revealed: - PA has seen the resident only once on 12/04/15. - PA was aware of resident's history of frequent falls but was unsure of the number of falls the resident had in the last 2 months. - PA stated the resident's lift chair was plugged on her medical visit to the facility on 12/04/15.	D 270		

Division of Health Service Regulation

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D 270	Continued From page 45 - During her visit at the facility on 12/04/15, Resident #4 independently used lift chair to assist him to stand. Resident used his walker to ambulate independently to bathroom and resident was able to come out of the bathroom without assistance and stepped up on the PA's scales to be weighed. - No one from the facility contacted her prior to unplugging the resident's lift chair nor discussed any other needed fall precautions. Interview with Resident #4's family member on 12/15/15 at 2:25 p.m. revealed: - She was concerned with resident's balance and feels like if he doesn't have someone to help him get up then he falls. - Resident #4 was able to use the lift chair independently to stand. - The HWD talked with the family member last week and the HWD voiced concerned for Resident #4's safety using his lift chair. HWD stated Resident #4 was unsafe using lift chair and was dumped out of the chair if the resident raised the chair up too early or if the resident started to get up too early with the lift chair and lost his balance. - HWD had prior discussion with resident and HWD had unplugged the lift chair in Resident #4's room. - She was not notified or consulted about the lift chair being unplugged. - She was told by the HWD that the use of lift chair was causing a safety issue and the chair needed to be changed for the resident's safety. - She did not feel like she had a choice in removing the lift chair and replacing it with the recliner based on the HWD's concerns. - The resident cannot get to a standing position with the new recliner. - She reported that staff now comes and checks	D 270		

Division of Health Service Regulation

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D 270	Continued From page 46 on resident about once an hour since over this last weekend. Review of Resident #4's records revealed: - No documentation of any falls caused by the use of the lift chair. Interview with Resident #4 on 12/15/15 at 2:25p.m. with family revealed: - Resident stated that unplugging the lift chair killed the power so he was not able to get up from the lift chair. - Resident reported that staff "comes and checks on me about every hour or so". Refer to four confidential staff interviews. Refer to interview with the Resident Care Coordinator (RCC) on 12/15/15 at 1:00 p.m. Refer to interview with the Health and Wellness Director (HWD) on 12/10/15 at 4:00 p.m. Refer to interview with the Regional RN on 12/15/15 at 10:30 a.m. _____ Confidential staff interview revealed: - The staff member had not received any training or information specific to individualized fall interventions for each resident. - Physical therapy (PT) was usually the first intervention when a resident had multiple falls. Confidential interview with a second staff member revealed: - The staff member received "in-service" training on "slips, trips, and falls in "October or November" 2015.	D 270		

Division of Health Service Regulation

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D 270	Continued From page 47 - The staff member checked residents who had multiple falls more frequently (could not give a specific time frame). - The staff member did more rounds on residents with fall risks. - The staff member had not received any training or communication related to individualized interventions for specific residents with falls. - The staff member knew from her previous jobs in Assisted Living facilities to check on residents every two hours and interventions such as more frequent checks to prevent falls. - The resident's care plan showed staff "what to do for the resident." - The resident care plans and staff assignment sheets were kept in the cabinet in the office for staff to review. - The staff member did not recall the resident care plans having individualized interventions for each resident with falls. - "When anyone falls we talk about it. We do not talk about specific interventions but we talk about what was done to make sure they are ok." - The facility had a "standup report meeting" every day at 09:30am to discuss "what's going on in the building." - "Everyone" [to include the HWD and ED] was at the meeting. - Verbal and written report was given to the oncoming shift about which included information on resident falls and changes in condition. Confidential interview with a third staff member revealed: - All residents are checked on every 2 hours. - The staff member provided "more checks" to residents who had falls. - The staff member was not aware of any specific or individualized interventions for	D 270		

Division of Health Service Regulation

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D 270	Continued From page 48 residents with falls. Confidential interview with a fourth staff member revealed: - It was facility procedure to complete an incident and fall report after a resident had a fall; "[the HWD] follows up after that." - Residents were checked on every two hours. - The staff member completed more frequent checks "maybe every 30 minutes to one hour" on residents with a risk for falling but the staff member was not sure how often other staff members checked on residents. Interview with the Resident Care Coordinator (RCC) on 12/15/15 at 1:00 p.m. revealed: - Residents were checked on "around every 2 hours and more if needed." - Residents were actually checked on more during the day because staff see them during activities and meals and many residents come to the living area to sit. - The facility had a fall policy. - Falls are communicated in the shift report and morning standup meeting. - The morning standup meeting provided staff with "more awareness" to perform more frequent checks on residents with falls. - Resident care plans show the "care needed by each resident." - The staff assignment sheets split the resident care into tasks for each shift. - The RCC "generates and prints" the assignment sheets. - The RCC did not have any knowledge about individualized fall interventions for each resident as referred to in the facility's fall policy. Interview with the HWD on 12/10/15 at 4:00 p.m. revealed:	D 270		

Division of Health Service Regulation

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D 270	Continued From page 49 - The facility did not have a policy on how often residents are supposed to be checked on. - Staff are trained to provide care to combative and confused residents. - Residents were watched more carefully if "they're having a bad day." - It was facility procedure to check on residents "as much as it makes sense." Interview with the Regional RN on 12/15/15 at 10:30 a.m. revealed: - The facility's electronic care plan system had "recently" began to provide options to include fall interventions in each resident's Personal Service Plan/Care Plan (PSPS/CP). - The Regional RN was unsure of the specific time frame of this change. - Prior to implementation of the electronic fall intervention options "there was a printed fall intervention sheet that were supposed to go with the PSP/CP's. - Any "yes response" on the facility's Risk Identification Evaluation indicated a fall risk. _____ Review of the facility's plan of protection dated 12/11/15 revealed: - Resident #1, #3, and #4 will be on hourly checks by staff or more often depending on symptoms until reassessed by HWD/designee. - Checks will be documented on flow sheets. - Health and Wellness Director (HWD), Resident Care Coordinator (RCC), and/or designee will immediately reassess all residents with frequent falls and interventions will be implemented. - Care Plans will be updated to reflect interventions. - Retraining for all staff that documents will be done by HWD/designee for acute documentation	D 270		

Division of Health Service Regulation

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D 270	Continued From page 50 and 72 hour follow-up (hot box). - HWD, RCC, and/or designee will update assignment sheets with interventions as needed. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 14, 2016.	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: FOLLOW UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-Compliance continues. THIS IS A TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure referral and follow up to meet the routine and acute health care needs of 4 of 5 residents sampled (#1, #2, #3, #4) related to a failure to seek medical evaluation for a resident taking Coumadin after a fall with a reported head injury, failure to notify the physician of side effects of pain medication, refusal of CPAP and complaints of dizziness for one resident (#1); weight gain for one resident (#2); complaints of pain after a fall resulting in injury and requiring sutures and failure to coordinate transportation for physician appointments for one resident (#3); and, failure to	{D 273}		

Division of Health Service Regulation

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{D 273}	Continued From page 51 notify the physician a gel seat cushion was not obtained for a resident with sacral decubitus and to coordinate podiatry care for on resident (#4). The findings are: 1. Review of Resident #1's current FL-2 and FL-2 addendum dated 04/27/15 revealed: - Diagnoses included coronary artery disease (CAD), cardiomyopathy, atrial fibrillation with pacemaker placement, Stage III chronic kidney disease, mild cognitive impairment, benign prostate hyperplasia (BPH), history of cerebrovascular accident (CVA), and pre-diabetes. - Resident #1 was intermittently disoriented. - Resident #1 was ambulatory. Review of the Resident Register revealed Resident #1 was admitted to the facility on 04/26/15. Review of Resident #1's record revealed: - Resident #1 had multiple physician orders for Coumadin. (Coumadin is a medication that decreases the chance of blood clots forming in the body. Coumadin can cause bleeding which can sometimes lead to death). - Resident #1's most current physician order for Coumadin was dated 11/20/15 for Coumadin 5mg. every evening. A. Review of the "Resident Log" for Resident #1 dated 12/03/15 revealed "Resident reported to staff that he had fallen backward in wheelchair and hit his head. He said he had been able to get himself up and pick up wheelchair. This is unlikely an actual fall due to resident's current health status." Interview with Resident #1 on 12/10/15 at 11:42	{D 273}			

Division of Health Service Regulation

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{D 273}	Continued From page 52 am revealed: - Resident #1 recalled falling "over and over." - Resident #1 had hit his head "several times" and recalled having "knots" on the back of his head on at least two occasions. - Resident #1 had last fallen "Sunday" (12/06/15) and was sent to the hospital. Observation and interview with Resident #1 on 12/11/15 at 3:00 pm revealed: - Resident #1 was sitting in the recliner in his room with his legs and feet propped up by his wheelchair. - Resident #1 was alert to person, place, and situation. - He was supposed to use his call bell to call staff before getting up or walking but he did not usually receive assistance from facility staff with transferring to/from his bed, recliner, or wheelchair. - "I do it (transfer) by myself" because "when I call them they don't necessarily come." - He did not know how many times he had fallen and hit his head but was not sent to the hospital. - He had a "knot" on the back of his head from his last fall on 12/06/15. Interview with a Medication Aide (MA) on 12/11/15 at 3:30pm revealed Resident #1 is usually alert and oriented. Confidential staff interview revealed: - Resident #1 had multiple falls beginning "3 or 4 months ago." - Resident #1 "really started declining" and kept falling when trying to go to the bathroom. - He is not supposed to get up or walk without calling staff for help. - If a resident had a fall resulting in head injury	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 53 "we have to send them out." - It was facility procedure to contact the resident's family and document the fall on the shift report. - The staff recalled there was an instance when Resident #1 said he fell and hit his head but he "was not sent out" [to the hospital]. - The staff member did not know why Resident #1 was not sent to the hospital for further evaluation, Confidential interview with a second staff member revealed: - When a resident had fall with a head injury or suspected head injury, the resident was sent to the hospital for further medical evaluation. - Resident #1 said he fallen backward out of his wheelchair (on 12/03/15). - "They [the Health and Wellness Director and Executive Director] said he probably wouldn't have been able to get himself up if he had fallen." - The staff member was not sure why Resident #1 was not sent to the hospital for further evaluation because the policy was to get further evaluation for any suspected or actual head injury. Confidential interview with a third staff member revealed: - When a resident "hit their head" it was facility policy to send them to the hospital for further evaluation. - When a resident had a head injury or suspected head injury, they "automatically go out" [to the hospital]. - Facility policy was "if they refuse (to go to the hospital), family or the responsible person must come to take them for follow up within 48 hours." - It was facility procedure to complete and incident and fall report; "[the HWD] follows up	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 54 after that." - Resident #1 had several falls which resulted in injury. - The staff member recalled Resident #1 hit his head "two" times and he had one "questionable" fall. - "He states he fell in the hall and hit his head." - The HWD had told the staff member about the incident on 12/03/15. - The staff member did not know why Resident #1 was not sent to the hospital because he was on Coumadin. - An incident report was completed even though Resident #1 did not go to the hospital on 12/03/15. Telephone interview with Resident #1's family member/Power of Attorney (POA) on 12/11/15 at 12:39pm revealed: - Resident #1 was "prone" to falls. - He was receiving physical therapy (PT) for his recent history of falling. - The POA had been in frequent contact with the facility's Health and Wellness Director (HWD) in regards to Resident #1's falls and plan of care. - Staff usually contacted him when Resident #1 falls or goes to the hospital. - The POA had no knowledge of any occasions when Resident #1 hit his head but was not sent for evaluation at the hospital. Interview with the ED on 12/14/15 at 11:10am revealed the HWD had access to the facility's fall policy and procedures and should be familiar with the policy and procedures. Interview with the Health and Wellness Director (HWD) on 12/14/15 at 4:55 pm revealed the HWD was aware of the facility policy and procedures for falls.	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 55 Interview with the Registered Nurse (RN) at Resident #1's Primary Care Physician (PCP) office on 12/14/15 at 2:50pm revealed: - Resident #1 had a recent history of multiple falls with diagnoses including right rib fracture and pneumothorax. - The facility was usually good about contacting the PCP office when Resident #1 fell; "they fax us." - The PCP had no record of being contacted about Resident #1 falling or hitting his head on 12/03/15. Interview with the Executive Director on 12/11/15 at 11:15am revealed: - The ED was aware Resident #1 said he had fallen and hit his head on 12/03/15. - The ED recalled the HWD felt like it was "unlikely" Resident #1 fell; "I remember her saying that to me." Interview with the ED on 12/15/15 at 12:45pm revealed: - Resident #1's physician had not been contacted about the incident on 12/03/15 when Resident #1 said he fell out of his wheelchair and hit his head. - The ED expected the fall policy to have been followed on 12/03/15. - Resident #1 reported a head injury which indicated he was supposed to be sent to the hospital for further medical evaluation. - Even though the HWD assessed Resident #1 on 12/03/15, he should have been sent for further medical evaluation because he was on Coumadin. B. Review of the Resident Log for Resident #1 dated 10/28/15 at 5:30am revealed: "Resident fell	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 56 in his bathroom against metal bar. " Review of the hospital discharge summary dated 10/28/15 revealed: - Diagnoses included fall, pneumothorax (collapsed lung), and "fracture of one rib." - Resident #1 was "oriented x4." - Orders for Percocet 5/325mg 2 tablets every 6 hours as needed for pain. (Percocet is a medication used in the treatment of moderate to severe pain). Review of the Resident Log revealed: - 10/29/15 no time: Documentation by the HWD that Resident was doing "fair since fall." Complains of pain with coughing and repositioning. Tolerating pain medication well." - 11/01/15 at 04:30am: Resident was using his call bell every "15 to 30 (sic) for pain." Resident could not get comfortable. - 11/02/15 at 04:30am: Resident was "up and down ...calling a lot." Review of the Shift Reports revealed: - 10/31/15: Resident #1 was calling staff " all night. " - 11/01/15: Resident #1 complained of pain; " calling a lot. " - 11/02/15: Resident #1 could not get comfortable in or out of bed. - 11/03/15: Resident #1 " did not sleep at all. " Review of Resident #1's October 2015 Medication Administration Records (MARs) and Narcotic Count Sheet revealed: - A handwritten entry for Percocet 5/325mg. one every 6 hours as needed for pain. - Resident #1 was administered Percocet at 9:00am, 3:00pm, and 9:00pm on 10/29/15 with response of "effective."	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 57 - Resident #1 was administered Percocet at 9:00am and 3:00pm on 10/30/15 with response of "slightly effective." - There was no documentation on the MAR that Resident #1 was administered Percocet at any other time in October. Review of the Resident #1's November 2015 MARs and Narcotic Count Sheet revealed: - A handwritten entry for Percocet 5/325mg. One tablet every 6 hours as needed for pain - Resident #1 was administered Percocet at 9:00am, 3:00pm, and 9:00pm on 10/29/15. - Resident #1 was administered Percocet at 03:00am, 09:00am, 3:00pm, and 9:00pm on 10/30/15. - Resident #1 was administered Percocet at 03:00am and 6:30 (no documentation if am or pm) on 10/31/15. - Resident #1 was administered Percocet at 06:45am on 11/01/15. - Resident #1 was administered Percocet at 12:15am and 09:00am on 11/02/15. Confidential staff interview revealed the staff member recalled after Resident #1 fractured his rib, he was "totally confused on his pain pills" until the medication was changed. Interview with the contracted Physical Therapist on 12/11/15 at 9:20am revealed: - Resident #1 was "out of it" when taking Percocet. - Resident #1 was not as alert, was more confused, and could not get out of bed or walk. - Resident #1's POA told her he was worried Resident #1 was going to fall again because of the side effects of the Percocet. - The POA told the Physical Therapist that Resident #1 was still in pain and needed	{D 273}			

Division of Health Service Regulation

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{D 273}	Continued From page 58 something for pain but did not want Resident #1 to fall again. - The POA called Resident #1's Primary Care Provider (PCP) to request more pain medication for Resident #1 and suggested changing the pain medication Percocet to Tramadol during the day so Resident #1 would not be so confused and would be able to walk. Review of the electronic Clinical Notes dated 11/03/15 from the physical therapy provider revealed: - The Physical Therapist arrived for Resident #1's physical therapy and his POA was with him. - The POA told the Physical Therapist Resident #1 did not sleep at all the previous night. - The POA told the Physical Therapist "patient was unable to walk while on Percocet but it helps with pain." - "Called [Resident #1's PCP] office ...regarding supplementing Tramadol for daily Percocet to decrease fall risk ..." Telephone interview with Resident #1's family member/Power of Attorney (POA) on 12/11/15 at 12:39pm revealed: - Resident #1 was confused and not able to get out of bed or walk after taking the Percocet, which increased his risk of having another fall. - The Percocet order ran out and Resident #1 was still in pain. - The HWD was aware of the effects the Percocet had on Resident #1 because they had discussed it. - The POA did not know if the HWD was aware Resident #1 ran out of pain medication and was still in pain. - The POA did not know if Resident #1's confusion was due to his pain, him not sleeping the previous night, or being caused by the	{D 273}			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 59 Percocet. - The POA talked to the Physical Therapist about Resident #1's pain and the Percocet order. - The Physical Therapist told the POA she would call the PCP to check about getting Resident #1 more pain medication and changing the Percocet for use at night only to help him sleep. - Resident #1's PCP changed his pain medication. - The new medication was more effective at controlling his pain during the day and he was able to get up and walk. Review of Resident #1's record revealed: - A physician order dated 11/03/15 for Tramadol/Acetaminophen 37.5/325mg. Take one twice daily as needed for rib pain. (Tramadol is a medication used to treat and prevent pain). - A physician order for Percocet 5/325mg. Take one every 6 hours as needed for pain. Interview with Resident #1 on 12/15/15 at 09:50am revealed: - Resident #1 did not know if he was prescribed a pain medication for the rib fracture that caused him to be confused and unable to walk. - Resident #1 did not know when or if his pain medication was changed. - Resident #1 remembered the rib fracture caused him "significant pain." Interview with the Health and Wellness Director (HWD) on 12/15/15 at 10:55am revealed: - The HWD was "unsure" if Resident #1 had "issues" with his pain medication. - The HWD had just returned from medical leave and "visited" with Resident #1 to "see how he was doing."	{D 273}		

Division of Health Service Regulation

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{D 273}	Continued From page 60 - "He talks and moves slow anyway." - Resident #1 was not "gorked out" when she talked to him. - When she saw and talked to Resident #1 she didn't see "that big of a change." - Resident #1 was doing "fair" when she checked on him; he was sore and struggling to move; he was not in any distress but he was not his normal self. - The Medications Aides (MAs) were "primarily" responsible for notifying the physician whenever a resident had adverse effects from a medication. - Even though the MAs were unlicensed, the HWD expected the MAs to notify the physician and also notify her so she could assess the resident. - Resident #1's POA told the HWD that he did not want Resident #1 on Percocet so she thought the order was changed when he went to his follow up appointment. - The HWD was not aware that the Physical Therapist contacted Resident #1's PCP or was involved in getting the Percocet order changed. Telephone Interview with the Registered Nurse (RN) at Resident #1's PCP office on 12/14/15 at 2:50pm revealed: - The Physical Therapist had contacted the PCP office about "concerns" with Resident #1's pain medication on 11/03/15. - The PCP wrote orders for Tramadol and a decrease dose of Percocet for Resident #1 on 11/03/15. Interview with the Executive Director (ED) on 12/15/15 between 11:15am and 12:05pm revealed: - The ED remembered Resident #1 being more confused on 11/01/15 and 11/02/15 but she was unsure if the confusion was related to his	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 61 pain medication. - The ED was unaware that Physical Therapy contacted Resident #1's PCP regarding his pain medication. - The ED expected the HWD to assess Resident #1 for adverse side effects to his medications and contact the prescribing provider as needed. C. Observation on 12/11/15 at 3:00 pm revealed Resident #1 had a CPAP (continuous positive air pressure) machine in his room beside his bed. (CPAP is a device that uses mild air pressure to keep the airways open. CPAP typically is used by people who have breathing problems, such as sleep apnea). Review of Resident #1's record revealed a physician order dated 10/12/15 for Resident #1 to self-administer his CPAP. Interview with Resident #1 on 12/1/5/15 at 09:50am revealed: - Resident #1 had a "breathing machine" [CPAP]. - The CPAP made a funny noise but it did help him sleep. - Resident #1 did not wear his "breathing machine last night." - Resident #1 did not use the CPAP because "the water in it is too old." - He did not know how often the water needed to be changed in the CPAP; "I just know it's been in there a long time." - Resident #1's family helped him change the water and clean the CPAP. - Resident #1 could not remember the last time he wore the CPAP but it helped him "sleep better." - Resident #1 stated "I don't know if I can get it	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 62 [CPAP] on without help." - Resident #1 did not know if his physician or family was aware he was not wearing his CPAP. Review of Resident #1's most current PSP/CP dated 11/09/15 revealed: - "Uses CPAP or BiPAP." - "CPAP at bedtime." - "Resident is independent with using oxygen or respiratory equipment." - The PSP/CP was signed by the HWD and dated 11/18/15. Review of the Licensed Health Professional Support (LHPS) review and evaluation for Resident #1 revealed: - 08/14/15: Resident #1 had CPAP. The LHPS Review form was not signed by a licensed health professional. - 10/01/15: Resident #1 had CPAP. The LHPS Review form was signed by the Health and Wellness Director (HWD) and dated 10/01/15. Confidential staff interview revealed: - Resident #1 does not use his CPAP device "too often." - "He told me he didn't need it." - When Resident #1 used his CPAP he required assistance from staff. Telephone interview with Resident #1's family member/Power of Attorney (POA) on 12/11/15 at 12:39pm revealed: - Resident #1 had a CPAP device. - Resident #1 does not use his CPAP. - Resident #1 had been refusing his CPAP for "a while." - The POA did not know if Resident #1 would be able to use the CPAP independently at this time.	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 63 - "They would give him help (with the CPAP), but it would cost \$400.00 more a month so he refuses it." - The Health and Wellness Director (HWD) was aware Resident #1 refused his CPAP because it was discussed when she "increased" his care plan in November 2015. - The POA did not know if the facility had notified Resident #1's physician that he was not wearing his CPAP. Interview with the HWD on 12/15/15 at 10:55am revealed: - Resident #1 had a CPAP device. - Resident #1 had a physician order to use the CPAP independently. - The HWD had not assessed Resident #1's use of the CPAP independently but he had used it "at home" independently. - Resident #1's POA helps him clean the CPAP. - The HWD was not aware Resident #1 was noncompliant with use of his CPAP. - The HWD "cannot assume" Resident #1's physician was notified he was noncompliant with the CPAP device. Interview with the Executive Director on 12/15/15 at 11:15am revealed: - Resident #1 had a CPAP device which he used independently. - Resident #1 had a physician order to use his CPAP independently. - The ED was unsure how or when Resident #1's CPAP was cleaned. - The ED had no knowledge of Resident #1's noncompliance with his CPAP device. D. Review of Resident #1's current FL-2 and FL-2 addendum dated 04/27/15 revealed an order to	{D 273}			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 64 check blood pressure weekly. Review of the Medication List from Resident #1's primary care provider (PCP) revealed: - A handwritten entry to check blood pressure monthly. - The order was signed by the physician and dated 04/30/15. Interview with Resident #1 on 12/11/15 at 3:00pm revealed: - Resident #1 was alert and oriented. - Resident #1 had a history of multiple falls. - When Resident #1 got out of his chair to stand up "I feel different. It could be dizziness I guess." - Resident #1 did not know how long he had been getting dizzy upon standing. - Resident #1 thought his Power of Attorney (POA) was aware he was dizzy upon standing. - Resident #1 thought he [Resident #1] had told staff he got dizzy upon standing. - Resident #1 recalled having his blood pressure checked "sometimes" by staff. - Resident #1 did not know how often staff checked his blood pressure. - Physical therapy (PT) checked his blood pressure each time he received PT. - The Physical Therapist had told him that "my blood pressure got low when I stood up." Interview with the contracted Physical Therapist on 12/11/15 at 9:20am revealed: - Resident #1 began PT on 10/14/15 due to multiple falls. - Resident #1 fell "3 or 4 times" after PT was initiated. - Resident #1 had been complaining recently of dizziness so she had evaluated him for orthostatic hypotension that day (12/11/15).	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE NEW BERN		STREET ADDRESS, CITY, STATE, ZIP CODE 1336 SOUTH GLENBURNIE ROAD NEW BERN, NC 28562		
(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 65 - Resident #1's blood pressure was 100/60 when he was sitting and dropped to 80/58 when he stood up. - The facility should be aware Resident #1's blood pressure dropped upon standing. - The Physical Therapist was "concerned" about Resident #1 because the facility did not follow each resident's care plan. - "Nobody is going to follow up with his plan of care." - The Physical Therapist was going to document Resident #1's drop in blood pressure in the physical therapy notes and notify his physician. Review of Resident #1's current Personal Service Plan/Care Plan (PSP/CP) dated 11/09/15 revealed: - Resident had #1 had fallen with injury requiring ER (emergency room) treatment. - "Consider possibility of orthostatic hypotension and respond as needed." Review of Resident #1's record revealed: - There was no documentation of Resident #1's complaint of dizziness upon standing. - There was no documentation Resident #1's PCP had been notified he was dizzy. - There was no documentation Resident #1 had been evaluated by the facility for orthostatic hypotension. Review of the "Resident Weight Record" revealed: - Resident #1's blood pressure was checked once monthly. - October 2015: Resident #1's blood pressure was documented as 102/74; the Health and Wellness Director 's (HWD) signature was documented beside the entry.	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 66 - November 2015: Resident #1's blood pressure was documented as 104/70; the HWD signed the entry. - December 2015: Resident #1's blood pressure was documented as 114/68; the HWD signed the entry. Telephone interview with Resident #1's POA on 12/11/15 at 12:39pm revealed: - Resident #1 was "prone to falls" and received PT. - Resident #1's complains of being dizzy "a lot" and the complaint had been ongoing for "awhile." - The POA had discussed Resident #1's complaint of dizziness with the Health and Wellness Director (HWD). - Resident #1 "seemed weak and faint" during the week of Thanksgiving (11/25/15) and was taken to the hospital for evaluation. - Resident #1's blood pressure was checked by PT. - The POA was not sure if the facility checked Resident #1's blood pressure. - The POA was aware Resident #1 had "heart problems" but had no knowledge of Resident #1 having any problems with his blood pressure. - The POA had not been contacted by the facility about any problems with Resident #1's blood pressure. - The POA did not know if Resident #1's physician had ever been notified about his blood pressure. Review of the hospital discharge summary dated 11/25/15 revealed diagnoses included "synope." Interview with the Resident Care Coordinator (RCC) on 12/11/15 at 3:30pm revealed: - Resident #1's original FL-2 dated 04/27/15 contained an order for weekly blood pressure	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE NEW BERN		STREET ADDRESS, CITY, STATE, ZIP CODE 1336 SOUTH GLENBURNIE ROAD NEW BERN, NC 28562		
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{D 273}	Continued From page 67 checks but she [the RCC] had clarified the order on 04/30/15 for monthly blood pressure checks. - Resident #1's blood pressure was checked monthly at the facility's "Wellness Clinic." - The RCC and Health and Wellness Director (HWD) were responsible for the Wellness Clinic which involved checking resident's blood pressures and weights. - The RCC provided documentation from the Wellness Clinic on the "Resident Weight Record" of Resident #1's monthly blood pressure checks. Interview with the HWD on 12/15/15 at 10:30am revealed the HWD was unaware Resident #1 complained of being dizzy upon standing. Interview with the Executive Director on 12/11/15 at 4:00pm revealed the Wellness Clinic is conducted on the first Friday of every month by the RCC and HWD. Telephone interview with a Registered Nurse (RN) at Resident #1's PCP office on 12/14/15 at 2:50pm revealed: - The PCP office expected to be notified of changes in Resident #1's status or blood pressure. - The PCP was not notified by the facility that Resident #1 was complaining of being dizzy upon standing. - The PCP office had not been notified of any problems with Resident #1's blood pressure. Telephone interview with the Licensed Practical Nurse (LPN) at Resident #1's cardiology office on 12/15/15 at 1:45pm revealed: - The facility had not notified the cardiology office of changes in Resident #1's blood pressure or complaints of dizziness. - Resident #1 had an appointment scheduled	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 68 in the office for 01/12/16. - The Physical Therapist had notified the cardiology office the previous day that Resident #1's blood pressure had been dropping when he stood up. - The cardiology office would contact the facility about scheduling an appointment for Resident #1 for a sooner date. Review of a fax from Resident #1's Cardiology office received 12/15/15 at the facility dated 12/15/15 revealed: - "Physical therapy reporting drops in BP (blood pressure)." - "Please call and have patient's office visit with [cardiologist] moved up. Can't wait until mid-January." - "Needs meds (medications) adjusted ..." 2. Review of Resident #3's current FL-2 dated 04/24/15 revealed: - Diagnoses included encephalopathy, acute on chronic atrial fibrillation, cardiomyopathy, history of lymphoma, and advanced dementia. - Resident #3 was ambulatory. - Resident #3 was intermittently confused. Review of the Resident Register revealed Resident #3 was admitted to the facility on 04/24/15. A. Interview with Resident #3's POAs on 12/14/15 at 1:00pm revealed: - The POAs lived out of state but visited Resident #3 at the facility once a month for multiple day visits. - Resident #3 had missed two scheduled medical appointments because her scheduled transportation did not arrive to take her to the appointments.	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 69 - The POAs recalled one incident (could not remember the date) when a Medication Aide (MA) notified them by telephone that transportation did not show up to take her to a physician appointment even though the facility had called to schedule and confirm the transportation appointment. - The POAs thought Resident #3 may have missed a podiatry appointment due to lack of transportation but they were not sure. - When Resident #3 moved in to the facility in April 2015, the facility had their own van to transport her to her appointments; "but that didn't last." - Resident #3 had an appointment scheduled with her Primary Care Provider (PCP) on 09/21/15 for follow up to the fall on 09/18/15. - Resident #3's appointment with the PCP on 09/21/15 had to be rescheduled because "the van did not come." - Resident #3's appointment was rescheduled from 09/21/15 to 09/25/15. - The PCP "took the stitches out then (09/25/15)." - The HWD called the POAs after Resident #'s appointment with her PCP on 11/27/15 and said she had a UTI. - The POAs did not know if Resident #3's appointment with her PCP on 11/25/15 had been delayed or rescheduled to 11/27/15. Review of the Resident Log revealed: - 09/18/15 at 7:00am: Resident #3 called staff to tell them she had fallen the night before; "she nor her husband could tell us when she fell or where she was found in her bed with a big mark on the left side of her face and eye. Her face was bleeding and she had sores on both of her legs that was [sic] bleeding called 911." - 09/18/15 at 11:30am: Resident returned from	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE NEW BERN		STREET ADDRESS, CITY, STATE, ZIP CODE 1336 SOUTH GLENBURNIE ROAD NEW BERN, NC 28562		
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{D 273}	Continued From page 70 the emergency room (ER) with suture to her face. "Has appointment with Primary Care Provider Mon. 21 (at) 2:15." Review of the hospital discharge summary dated 09/18/15 revealed: - Diagnoses included "unspecified fall, abrasion or friction burn of hip, thigh, leg or ankle without mention of infection, contusion of face, facial laceration, and open wound of face." - Follow up instructions included "follow-up with your doctor or here in in the emergency department in 2 days for wound check." Review of the Resident Log revealed: - 09/24/15: Documentation by the HWD "Right leg sores are closed, no drainage, redness noted around wounds. Has MD appointment tomorrow will ask them to check these areas." - 09/25/15: Resident #3 returned from a doctor appointment with an order for Levaquin 500 mg twice daily for 7 days "for leg" documented by the HWD. (Levaquin is a medication used to treat infection). Review of the Progress Note dated 09/25/15 and electronically signed by Resident #3's Primary Care Physician (PCP) revealed: - Resident #3 was evaluated in the PCP office on 09/25/15 for follow up to a fall. - The PCP office removed the suture from above Resident #3's right eye - Resident #3 "has gotten more inflammation and redness in her right leg" and the facility requested the PCP evaluate the leg. - Resident #3 's right leg had "several scabs with some warmth and erythema (redness) around them." - The PCP wrote an order for "Levaquin 500mg daily for 7 days.	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 71 Review of the shift report dated 11/24/15 revealed: - 7:00pm-7:00am: Resident #3 fell 5 times and was sent to the hospital emergency department. - "Resident continues to be very off balance; continuous falls." Review of the Resident Log dated 11/24/15 at 7:20pm revealed: - Resident #3 had returned to the facility from the hospital emergency department. - Resident #3 was supposed to follow up with her PCP in 2-3 days. - Resident #3 had an appointment scheduled with her PCP on 11/25/15 at 11:20am. Review of the hospital discharge summary dated 11/24/15 revealed: - Diagnoses included fall and dementia. - Instructions for follow-up with her Primary Care Physician (PCP) in "2-3 days." Review of the Resident Log dated 11/27/15 revealed: - Resident #3 returned from an appointment with her PCP on that date. - Resident #3 had a new order for Cipro 250mg. one tablet twice daily for 7 days. (Cipro is a medication used to treat infection). - The HWD was with Resident #3; her POAs were contacted by telephone. Review of the Progress Note dated 11/27/15 and electronically signed by the PCP on 11/28/15 revealed: - Resident #3 was evaluated in the PCP office on 11/27/15 for "follow up of several recent falls." - "The folks at the rest home do not think that she is acting quite herself."	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 72 - "Staff is worried she may have a UTI" (urinary tract infection). - Resident #3 had "little or no complaints." - Orders for Cipro 250mg. twice daily for 7 days; "she may well have a urinary tract infection." Interview with the Health and Wellness Director (HWD) on 12/11/15 at 3:45pm revealed Resident #3's appointments on 09/21/15 and 11/25/15 were "probably" changed "because "[Resident #3's POAs] wanted to go" [to the appointment with her]. Observation and interview with Resident #3 on 12/10/15 at 10:59am revealed: - Resident #3 was in her room with her husband. - Resident #3 was neatly groomed. - Resident #3's husband stated "she keeps falling." - Resident #3 did not remember falling; "I'll be darned if I can remember that. I don't think he is right. I did not fall." Resident #3 was not interviewed about the missed physician appointments because she was not alert to time, place, or situation. Confidential staff interview revealed: - Resident #3 had missed "at least one" physician appointment due to transportation not coming to get her. - Staff could not recall the date Resident #3 missed the medical appointment due to lack of transportation. Confidential interview with a second staff member revealed: - The staff member recalled the facility having	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 73 to reschedule a physician appointment for Resident #3 because transportation "didn't come to take her." - The staff member could not recall the date of the missed or rescheduled appointment. Interview with the Health and Wellness Director on 12/14/15 at 4:55pm revealed: - "It sounds like [the contracted transportation provider] missed picking her up so the appointment was rescheduled to 09/25/15." - The facility used a contracted transportation provider. - The facility had problems with the contracted transport service not showing up to transport residents to scheduled appointments. - In the event the contracted transportation service did not show up as scheduled to transport a resident, the facility did not have a back-up plan in place. Interview with the Executive Director (ED) on 12/14/15 at 4:40pm revealed: - The facility used a contracted outside transportation service. - It was facility procedure to fax and call the contracted transport provider to arrange/confirm transportation services for residents. - Resident #3 had a history of two missed physician appointments because the outside contracted transportation service had not shown up to pick up Resident #3. - The HWD had called the contracted transportation service and spoke with the supervisor. - The transportation supervisor told the ED "they dropped the ball." Interview with the ED on 12/15/15 at 11:15am revealed:	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 74 - The ED was unsure of the two dates when Resident #3 missed her medical appointments because transportation failed to come to transport her. - The facility's back-up plan if the contracted transportation provider did not show was "we have to reschedule the appointment." B. Review of the Resident Log for Resident #3 revealed: - 09/18/15 at 11:30am: Resident returned from the emergency room (ER) with suture to her face. - 09/19/15 at 4:00am: Resident #3 "said last night that her face was hurting and wanting something for it but she did not have anything order (sic) for pain." Resident #3 was "picking" at her sutures and was told by staff not to pick at the sutures. Review of Resident #3's record revealed: - There was no documentation Resident #3's Primary Care Provider (PCP) had been notified of her facial pain. - There were no physician orders for pain medication. Confidential staff interview revealed: - The staff member recalled Resident #3 complaining of facial pain and picking at her sutures. - Resident #3 complained of facial pain "at times." - Resident #3 did not have any orders for pain medication. - The Staff member "talked to [the HWD] about it and she said she would follow up with the MD (doctor)." - To the staff member's knowledge, Resident #3 never got any pain medication.	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 75 Confidential interview with a second staff member revealed the staff member had no knowledge of Resident #3 picking at her sutures and complaining of pain in her face. Confidential interview with a third staff member revealed the staff member was unsure if Resident #3 had complained of pain in her face without reviewing her record. Interview with Resident #3's POAs on 12/14/15 at 1:00pm revealed: - Resident #3 had not complained of facial pain to the POAs. - The POAs were unaware and were not notified Resident #3 complained of pain in her face. - The bruise on her face "looked bad; it had taken "a while for the bruise to heal." - The POAs did not know if Resident #3 received any medication for pain. - The POAs "would expect" Resident #3 to receive pain medication if she was complaining of pain. Review of the Shift Report dated 09/19/15 at 7:00pm-7:00am revealed: - Resident #3 complained her face "hurt" but did not have any pain medication ordered. - "So I will have 1st shift try to call in the morning and get an order for something." - The Shift Report was signed by the Health and Wellness Director and dated 09/21/15. - The Shift Report was signed by the Executive Director and dated 09/21/15. Interview with the Health and Wellness Director on 12/14/15 at 4:55pm revealed; - The HWD had never heard Resident #3 complain of pain.	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 76 - The HWD was not aware Resident #3 had complained of facial pain from the injuries sustained from her fall on 09/18/15. - The HWD acknowledged the documentation on the shift report dated 09/19/15 that Resident #3 was complaining of facial pain and did not have any current physician orders for pain medication. - The HWD did not notify Resident #3's PCP about her facial pain. - To the HWD's knowledge, Resident #3 never received any pain medication. Interview with the Executive Director (ED) on 12/15/15 at 11:15am revealed: - The ED had no knowledge of Resident #3 complaining of pain or picking at her sutures. - The ED could not recall that the information had been shared during report. 3. Review of Resident #4's current FL-2 dated 12/04/15 revealed: - Diagnoses included chronic venous insufficiency, peripheral vascular disease, and gait disturbance. A. Review of Resident #4's Resident Register revealed: - He was admitted to the facility on 11/17/14. - The resident needed assistance with dressing, bathing, ambulation, getting in and out of bed, toileting, skin care, and scheduling appointments. - The resident was forgetful and needed reminders.	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 273}	Continued From page 77 Review of Resident #4's assessment and care plan dated 08/05/15 revealed the resident required physical assistance with dressing and grooming related to balance and coordination issues. Observation of Resident #4 on 12/15/15 at 10:15 a.m. revealed: -Thick, yellowish toenails were observed with varying lengths approximately ¼ to ½ inch long and curled over the top of Resident #4's toes on both feet. Interview with Resident #4 on 12/15/15 at 10:15 a.m. revealed: - He was unsure of the last time his toenails were cut. - Resident #4 denied any pain to his toenails or feet. - Resident #4 stated that "the nurse comes and cuts my toenails". Interview with a Resident Assistant on 12/15/15 at 10:20 a.m. revealed: - Staff does not cut residents' fingernails or toenails in the facility. Interview with Health and Wellness Director on 12/15/15 at 12:15pm revealed: - She was not aware that Resident #4's toenails were long and curling. - The previous provider from the resident's primary care group used to file and cut his toenails. - The new provider has only seen the resident once. - She was not sure if the new provider would provide toenail care for the resident. - The facility staff can file but not cut toenails per the facility policy.	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE NEW BERN		STREET ADDRESS, CITY, STATE, ZIP CODE 1336 SOUTH GLENBURNIE ROAD NEW BERN, NC 28562		
(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 78 - If toenails need trimming, they will have to get podiatry appointment. - She has told families they need to go to podiatry. - She was not sure if podiatry had been discussed with Resident #4's family. - No staff have reported any concerns about Resident #4's toenails. - She would make sure to make an appointment for Resident #4 to be seen by podiatry. Interview with Resident #4's primary physician's assistant (PA) on 12/15/15 at 1:17 p.m. revealed: - PA has seen the resident only once on 12/04/15. - PA was not aware Resident #4's toenails needed to be cut. - According to the provider notes, Resident #4's toenails were cut by a former provider from their office in August 2015. - Facility had not contacted PA to have Resident #4's toenails cut. B. Review of Resident #4's record revealed: - There was an order from the physician dated 10/22/15 for Resident #4 to have a standard gel seat cushion to be used daily for a Stage II decubitus. Interview with Resident #4 on 12/11/15 at 2:50 p.m. revealed Resident #4 reported he never had a gel cushion in his chair. Interview with Executive Director (ED) on 12/11/15 at 12:20pm revealed: - ED stated that gel seat cushion order was incorrect. - Resident #4 had been ordered to have an air mattress for his bed. - ED reported that since Resident #4 already had an air mattress for his bed that his insurance	{D 273}		

Division of Health Service Regulation

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{D 273}	Continued From page 79 would not pay for a gel seat cushion. - She believed that an air mattress was on Resident #4 bed. - ED stated that the physician was not notified that the resident was not able to get the gel seat cushion as ordered. Review of Resident #4's record revealed: - There was an encounter note from physical therapy (PT) dated 11/05/15 that revealed that PT had spoken with ED regarding the gel cushion for Resident #4 and that the ED stated that the gel cushion was ordered on 10/23/15 and the order had be faxed to durable medical supplier. - There was an encounter note from the medical provider dated 12/04/15 that stated sacral wound was healed but Resident #4 still complained of some mild burning and redness to Resident #4's sacral area. Interview with Resident Assistant (RA) on 12/15/15 at 9:40 a.m. revealed: - RA stated that Resident #4 had an air mattress on his bed. - RA stated that Resident #4 did not have a gel cushion in his chair. - RA stated that Resident #4 did not have any open areas to his sacral area and Endit cream was applied to the sacral area after each incontinent change as needed. Observation of Resident #4 on 12/15/14 at 10:00a.m. revealed that decubitus to sacral area was healed with dry flaky skin and slight redness to both lower buttocks. Interview with Health and Wellness Director (HWD) on 12/15/15 at 12:15 p.m. revealed: - The resident scoots in the chair to get up and that friction causes the open areas.	{D 273}		

Division of Health Service Regulation

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{D 273}	Continued From page 80 - She was unsure the last time she observed or assessed Resident #4's sacral area. Interview with Resident #4's primary physician's assistant (PA) on 12/15/15 at 1:17 p.m. revealed: - PA has seen the resident only once on 12/04/15. - PA was not aware that Resident #4 did not have gel cushion as ordered. - PA stated that Resident #4 would benefit from gel cushion to help prevent decubitus to sacral area. 4. Review of Resident #2's current FL-2 dated 10/21/15 revealed: - Diagnoses included asthma, congestive heart failure, muscle weakness, difficulty walking, closed fracture of 3 ribs, essential hypertension, pure hypercholesterolemia, and osteoporosis. - The resident was semi-ambulatory with walker and power chair. - The resident required assistance with bathing and dressing. Review of a licensed health professional support (LHPS) review dated 10/01/15 revealed: - The resident continued to have chronic edema to bilateral lower extremities. - The LHPS nurse noted the resident's weight at 163 pounds. Review of the Resident #2's monthly weight record revealed: - August 2015: 160 pounds. - September 2015: 163 pounds. - October 2015: 172 pounds. - November 2015: 171 pounds. - December 2015: 173 pounds. - The specific day of the month the weights were taken was not documented. - The section for the nurse's signature was	{D 273}			

Division of Health Service Regulation

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{D 273}	Continued From page 81 signed and a "Y" was documented in the column for MD notified. - No response or any other details was documented on the form regarding the physician's notification. Review of Resident #2's record revealed no documentation the physician was notified about the resident's weight gain of 9 pounds in one month from September 2015 to October 2015. Review of Resident log notes for Resident #2 revealed: - 09/29/15: Health and Wellness Director (HWD) documented the resident's left leg wound was healed and there was no redness, swelling, or drainage. - There was no further resident log notes documented until 10/21/15. - 10/21/15 (fill-in nurse for HWD): The resident has 2 to 3+ edema to right leg knee high and 4+ edema to left leg knee high. The physician was contacted and the resident's Lasix (diuretic) was increased. Review of notes from a physician's visit dated 10/27/15 revealed: - The resident was seen for bronchitis. - The resident was noted to have chronic edema and continue Lasix (a diuretic). - There was no documentation related to the resident's weight gain of 9 pounds from September 2015 to October 2015. Review of notes from a physician's visit dated 11/16/15 revealed: - The resident was seen for labwork. - The resident was noted to have usual ankle edema. - There was no documentation related to the	{D 273}		

Division of Health Service Regulation

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{D 273}	Continued From page 82 resident's weight gain of 9 pounds from September 2015 to October 2015 Interview with the Executive Director (ED) on 12/11/15 at 4:00 p.m. revealed: - She was unsure why there was a gap in the resident log notes for Resident #2 from 09/29/15 until 10/21/15. - The relief nurse assessed the resident on 10/21/15 because staff reported the resident's legs were swelling. - She did not know when it was noticed or reported but she thought it was reported the same day the nurse assessed the resident on 10/21/15. - Monthly weights were usually done on the first Friday of each month. - She did not know if Resident #2's physician was notified of the 9 pound increase from September 2015 to October 2015. - The HWD and Resident Care Coordinator (RCC) would be responsible for the weights and notifying the physician of any significant changes. - If the physician was notified, it should be documented in the resident's record. Interview with the Health and Wellness Director / Registered Nurse (HWD) on 12/15/15 at 11:50 a.m. revealed: - The "Y" for the MD notified column on the monthly weight form meant the HWD would have checked with the RCC to see if she notified the physician. - The goal for monthly weights was to weigh them on the first Friday of the month. - She was out for surgery around the first part of October 2015 and she was not sure if there was any follow-up with the physician about Resident #9's weight gain of 9 pounds in one month. - They have a monthly nutrition tracking follow-up	{D 273}			

Division of Health Service Regulation

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{D 273}	Continued From page 83 form that was used by the RCC to track weight changes. Review of the facility's monthly nutrition tracking follow up with physician's form for October 2015 revealed: - A handwritten entry dated 10/14/15 for Resident #2 with the physician's name. - The reason column had handwritten entry with increase 9 pounds "called MD". - There was no documentation to indicate who wrote any of the entries on the form. - There was no follow-up information documented on the form. Interview with the Resident Care Coordinator (RCC) on 12/15/15 at 1:15 p.m. revealed: - She usually filled out the monthly tracking form and notified the physicians. - She would have been responsible for notifying the physician of the weight increase for Resident #2. - She would have either left a message or talked with the nurse. - She did not recall if she left a message or spoke with a nurse for Resident #2's weight gain from September 2015 to October 2015. - She sometimes received a response from the physicians' offices and sometimes she did not. - There was no system to follow-up with the physician if no response was received. Telephone interview with a medical assistant for Resident #2's primary physician on 12/15/15 at 11:28 a.m. revealed: - She did not see any documentation of the facility notifying the physician's office of any weight increase from September 2015 to October 2015. - If someone from the facility would have called	{D 273}			

Division of Health Service Regulation

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{D 273}	Continued From page 84 or left a message they would have documented it in the resident's chart information and forwarded it to the physician. - There was no documentation of any contact from the facility on 10/14/15. - The physician's office was contacted on 10/21/15 about edema in the resident's legs and the Lasix was increased. - There was not documentation regarding a 9 pound increase in the contact from 10/21/15. Based on observation, record review, and interviews, Resident #2 was not available for interview on 12/14/15 due to being in the hospital for pneumonia, chronic obstructive pulmonary disease exacerbation, possible diastolic congestive heart failure and deep vein thrombosis. _____ Review of the facility's plan of protection dated 12/11/15 revealed: - The Health and Wellness Director (HWD), Resident Care Coordinator (RCC), and/or designee will immediately begin audit of records to assure changes in conditions have been communicated to primary care physicians (PCP) and follow-ups have been done. - The facility will implement a "hot box" for acute changes in resident condition. - Floor staff will report resident changes of condition to the medication aide, RCC, HWD, and/or designee. - Medication Aide, RCC, HWD, and/ or designee will report changes to the PCP and document in the Resident Log and on the Shift Report. - HWD and Executive Director (ED) review shift reports daily Monday through Friday. - Shift reports for the weekends will be reviewed on Mondays.	{D 273}		

Division of Health Service Regulation

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{D 273}	Continued From page 85	{D 273}			
	CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2016.				
{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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physician orders were implemented for 3 of 5 residents sampled (#1, #3, #4) for daily weights for one resident (#4); dressing changes for two residents (#3, #4); for CPAP, incentive spirometry and monitoring of bowel movements for one resident (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 04/24/15 revealed: - Diagnoses included encephalopathy, acute on chronic atrial fibrillation, cardiomyopathy, history of lymphoma, and advanced dementia. - Resident #3 was ambulatory. - Resident #3 was intermittently confused.	{D 276}			

Division of Health Service Regulation

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{D 276}	Continued From page 86 Review of the Resident Register revealed Resident #3 was admitted to the facility on 04/24/15. Review of the Resident Log revealed: - 09/18/15 at 7:00am: Resident #3 called staff to tell them she had fallen the night before; "she nor her husband could tell us when she fell or where she was found in her bed with a big mark on the left side of her face and eye. Her face was bleeding and she had sores on both of her legs that was [sic] bleeding called 911." Review of the Shift Reports revealed: - 09/20/15 7:00am-7:00pm: "Please take a look at [Resident #3's] legs per family." - 09/24/15 7:00am-7:00pm: "New orders to treat skin tear." Review of the Resident Log revealed: - 09/20/15 (no time documented): Documentation by the Health and Wellness Director (HWD) that Resident #3's right leg had "two small sores, no redness or drainage at this time." - 09/24/15 (no time documented): Documentation by the HWD "Right leg sores are closed, no drainage, redness noted around wounds. Has MD appointment tomorrow will ask them to check these areas." - 09/25/15: Resident #3 returned from a doctor appointment with an order for Levaquin 500 mg twice daily for 7 days "for leg" documented by the HWD. (Levaquin is a medication used to treat infection). Review of the Fax Physician Order Sheet dated 09/22/15 revealed: - The Resident Care Coordinator (RCC) contacted Resident #3 's primary care physician	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 87 (PCP) office with the message "received order to change her [Resident #3] dressing daily. Can we have a full order that's stated below to be more specific ...? " - "To treat skin tear on right knee": clean with normal saline, apply a thin layer of antibiotic ointment, and cover with dressing. Change daily and PRN (as needed) if soiled. " - The order was signed by the physician. Confidential staff interview revealed: - Resident #3 had an order for a dressing change "I think" and the order should be transcribed on her Medication Administration Record (MAR). - The Medication Aides (MAs) were responsible for completing dressing changes and initialing the MAR as documentation the task was complete. Confidential interview with a second staff member revealed: - Resident #3 had "red and painful sores" on her knees after falling (on 09/18/15). - The staff member "got in trouble with [the HWD]" and had been told by the HWD not to describe or write details about Resident #3's knee wounds in her record. - If there was no staff initial on the MAR beside of the dressing change entry, it meant Resident #3's dressing change was not done. Confidential interview with a third staff member revealed: - The MAs initialed the resident's MARs beside each medication or treatment entry for the corresponding date and time as documentation the medication or treatment had been administered. - The MAs circled their initials on the MARs	{D 276}			

Division of Health Service Regulation

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{D 276}	Continued From page 88 when a medication or treatment was not administered and document the reason it was not administered on the reverse side of the MAR. Review of Resident #3's September 2015 Medication Administration Records (MARs) revealed: - A handwritten entry dated 09/24/15 for "treat skin tear on right knee": clean with normal saline, apply a thin layer of antibiotic ointment, and cover with a dressing. "Change daily or PRN if soiled." - There was no documentation on the MAR that the dressing was changed on 09/26/15, 09/27/15, and 09/29/15. Review of Resident #3's October 2015 MARs revealed: - A handwritten entry dated 09/24/15 for "treat skin tear on right knee": clean with normal saline, apply a thin layer of antibiotic ointment, and cover with a dressing. "Change daily and as needed if it becomes soiled." - There was documentation the dressing was changed on 10/01/15-10/05/15. - Staff circled their initials as documentation the dressing change was not completed from 10/06/15-10/31/15. - There was no reason documented why the dressing change was not completed from 10/06/15-10/31/15. Review of Resident #3's November 2015 MARS revealed: - A handwritten entry to treat skin tear on right knee; clean with normal saline, apply a thin layer of antibiotic ointment, and cover with a dressing. Change daily and as needed if soiled. - Staff circled their initials as documentation the dressing change was not completed from 11/01/15-11/22/15 and 11/24/15-11/30/15.	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 89 - There was documentation dated 11/02/15, 11/07/15, 11/12/15, 11/13/15, 11/2015, 11/26/15, and 11/27/15 that the dressing was not changed because the skin tear was "healed." Review of the physician's orders revealed the dressing change was discontinued on 12/07/15. Observation and interview with Resident #3 on 12/10/15 at 10:59am revealed: - Resident #3 was in her room with her husband. - Resident #3 was neatly groomed. - She was alert to self; she was not oriented to time, place, and situation. - Resident #3's husband stated "she keeps falling." - Resident #3 did not remember falling. Resident #3 was not interviewed about the skin tear or dressing change because she was not oriented to time, place, and situation. Interview with Resident #3 's POAs on 12/14/15 at 1:00pm revealed: - When Resident #3 fell on 09/18/15 she had a "purple" bruise on her face and "skinned" both of her knees. - The POAs noticed Resident #3's right leg had scabs and became red and swollen. - The POAs requested to a Medication Aide (MA) that Resident #3's leg be evaluated by the facility nurse. - The MA told the POAs she would ask the Health and Wellness Director (HWD) to check Resident #3's leg. - The POAs had no knowledge of Resident #3 having an order for dressing changes for her right knee.	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 90 Interview with the HWD on 12/14/15 at 4:55pm revealed Resident #3 had "dementia so bad" that she didn't remember falling or "a problem with her leg." Interview with the HWD on 12/15/15 at 10:30am revealed: - The HWD recalled evaluating Resident #3's right leg on 09/20/15 and 09/24/15. - The wounds on Resident #3's right leg were healing on 09/20/15 but when she [the HWD] checked the wounds again on 09/24/15 she notice there was some redness around the wounds. - Resident #3 had a follow up appointment with her primary care physician (PCP) the next day (09/25/15) so the HWD requested the PCP evaluate the right leg at her follow up appointment. - The PCP wrote orders on 09/25/15 for an antibiotic to treat the infection in Resident #3's leg. - Resident #3's orders for dressing changes would be on her MARs. - MAs were responsible for completing dressing changes and documenting on the MARs. - The HWD did not know why Resident #3's dressing changes were not completed per the physician order (every day) even though Resident #3 had been diagnosed with cellulitis and was ordered antibiotics to treat the infection. Review of the Physician Visit form dated 09/25/15 revealed "Could you please look at [Resident #3's] leg." Review of the Progress Note dated 09/25/15 and electronically signed by Resident #3's Primary Care Provider (PCP) revealed:	{D 276}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE NEW BERN		STREET ADDRESS, CITY, STATE, ZIP CODE 1336 SOUTH GLENBURNIE ROAD NEW BERN, NC 28562		
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{D 276}	Continued From page 91 - Resident #3 was evaluated in the PCP office for follow up to a fall. - Resident #3 "has gotten more inflammation and redness in her right leg" and the facility requested the PCP evaluate the leg. - Resident #3 right leg had "several scabs with some warmth and erythema (redness) around them." - The PCP wrote an order for "Levaquin 500mg daily for 7 days for the cellulitis in her right leg." (Levaquin is a medication used to treat infection). Multiple attempts to contact with Resident #3's PCP by telephone during the survey revealed the PCP did not return the telephone calls during the survey. Refer to the interview with the Executive Director on 12/11/15 at 12:06pm. 2. Review of Resident #1's current FL-2 and FL-2 addendum dated 04/27/15 revealed: - Diagnoses included coronary artery disease (CAD), cardiomyopathy, atrial fibrillation with pacemaker placement, Stage III chronic kidney disease, mild cognitive impairment, benign prostate hyperplasia (BPH), history of cerebrovascular accident (CVA), and pre-diabetes. - Resident #1 was intermittently disoriented. - Resident #1 was ambulatory. Review of the Resident Register revealed Resident #1 was admitted to the facility on 04/26/15. A. Observation and interview with Resident #1 on 12/10/15 at 11:42 am revealed: - Resident #1 was dressed and neatly	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 92 groomed. - Resident #1 was alert and oriented. - Resident #1 was sitting in a wheelchair in the bedroom area of his room. - Resident #1 excused himself and went to the bathroom by shuffling his feet to move his wheelchair. - Resident #1 recalled falling "over and over." - Resident #1 had fractured his ribs as the result of a fall "which hurt real bad." Review of the "Resident Log" for Resident #1 revealed Resident #1 fell in his bathroom on 10/28/15 and returned from the hospital with diagnosis of rib fracture. Review of the Shift Report dated 10/28/15 revealed: - Resident #1 had fallen and was sent to the hospital. - Resident #1 had "broke [sic] rib." Review of the hospital "Discharge Summary" dated 10/28/15 revealed: - Diagnoses including fall, pneumothorax, and fracture of one rib. - Use the incentive spirometer (IS) as directed. (Incentive spirometry is a device used to teach the user how to take slow deep breaths in order to help keep the lungs healthy). Review of the Physician/Healthcare Provider Visit Form dated 10/30/15 revealed: - Purpose of visit: Follow up from emergency room visit; right pneumothorax (collapsed lung); right rib fracture; right lower lobe atelectasis (collapse of the small air sacs in the lungs). - Current findings included decreased breath sounds throughout both lung fields and right posterior flank pain.	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 93 - New order for "Please have patient use incentive spirometer every hour while awake." Observation and interview with Resident #1 on 12/11/15 at 3:00 pm revealed: - Resident #1 was alert and oriented. - Resident #1 did not appear to have any difficulty breathing. - There was no IS observed in his room. - He "fell against the bars in the in the shower" which resulted in "broken ribs." - Resident #1 did not know the date when he fractured his ribs. - The hospital gave him a "breathing machine" [incentive spirometer]. - "I don't guess I know how to use it." - Resident #1 was "not sure" how often he was supposed to use the IS. - Staff had not assisted in the use of the IS. - Resident #1 did not know where the IS was at that time; it had been on his table in the living room area, but he did not know what happened to it. - Resident #1 did not know if he was still supposed to be using the IS. - Resident #1's "[Power of Attorney (POA)] saw to it that I did it (IS)" when he was here. - Resident #1 did not recall any instances recently when he had been short of breath. Confidential staff interview revealed: - Resident #1 had an IS. - Staff did not assist him with the IS; "he does it himself." Confidential interview with a second staff member revealed: - The staff member recalled seeing the IS in Resident #1's room. - The staff member asked another staff	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 94 member about Resident #1's IS and was told he brought it back from the hospital and he did not require assistance with use of the IS. - The staff did not know if Resident #1 used the IS. - The staff did not recall ever observing Resident #1 using the IS. Confidential interview with a third staff member revealed: - Resident #1 had been ordered an IS after he had fallen and returned from the hospital. - The staff member was not sure how often Resident #1 was supposed to use the IS. - The staff member did not know if Resident #1 still had an active order for the IS. - Resident #1 used the IS without assistance from staff. - The IS should be documented on Resident #1's Medication Administration Records (MARs). - Staff were supposed to document when Resident #1 used the IS. - If the MARs were not initialed it meant "it was not done." Review of Resident #1's October 2015 MARs revealed there was no entry or documentation for IS on the MAR. Review of Resident #1's November 2015 MARs revealed: - There was a handwritten entry for IS "every hour while awake." - There was a "?" documented to the left side of the IS entry. - There was no documentation Resident #1 used the IS as ordered on the MAR. Review of Resident #1's December 2015 MARs revealed there was no entry or documentation for	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 95 IS on the MAR. Telephone interview with Resident #1's family member/Power of Attorney (POA) on 12/11/15 at 12:39pm revealed: - Resident #1 was given the "sucking balls to open his lungs" (IS) at the hospital. - Resident #1 "barely used it." - Staff did not assist Resident #1 to use the IS. - Resident #1 had been able to use the IS when the POA helped him. - Resident #1 had "stroke induced dementia" so he could not remember to use the IS or how to use IS without help. - The POA was not aware if Resident #1's physician had been notified he was not using the IS. Interview with the Health and Wellness Director (HWD) on 12/15/15 at 10:30am revealed: - Resident #1 should be independent with the IS. - The HWD was unsure if Resident #1 used the IS. - When the HWD talked to Resident #1 after his fall he was not in any acute respiratory distress. Interview with the Registered Nurse (RN) at Resident #1's Primary Care Physician (PCP) office on 12/14/15 at 2:50pm revealed: - Resident #1 was evaluated by the Physician Assistant (PA) in the PCP office on 10/30/15 for follow up to a fall resulting in a rib fracture and pneumothorax. - Resident #1 had been provided with an IS at the hospital and the PA re-wrote the order for the IS because Resident #1 had decreased breath sounds.	{D 276}			

Division of Health Service Regulation

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{D 276}	Continued From page 96 - Resident #1 was supposed to use the IS every hour while awake. - The expectation was for Resident #1 to use the IS throughout the day if he could not use it every hour. - The PCP office expected to be notified if Resident #1 was not able to use the IS. - The PCP office had not been notified Resident #1 was not using the IS. - The facility had contacted the PCP the previous day (12/13/15) to request a discontinue order for the IS. Refer to the interview with the Executive Director on 12/11/15 at 12:06pm. B. Review of the Physician/Healthcare Provider Visit Form for Resident #1 dated 10/30/15 revealed: - A new order to "monitor BM's" (bowel movements). - An order to "begin Miralax 1 scoop in 8 ounces of liquid" if Resident #1 did not have a BM every day. (Miralax is a laxative medication). Interview with Resident #1 on 12/11/15 at 3:00 pm revealed: - He had not had any problems with his BMs. - He did not know if staff checked his BMs. - He did not remember staff asking him about his BMs. Confidential staff interview revealed Resident #1's stools had not been checked "that I know of." Confidential interview with a second staff member revealed: - Resident #1's BMs were not checked. - The staff member had asked the Health and Wellness Director about the order to monitor	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 97 Resident #1's BMs because the staff member was not sure what to do. - The staff member asked the HWD "how we would do that" because the staff had been told "we are not RNs" (Registered Nurses). - The HWD told the staff member "not to worry about it" because she was trying to get the order discontinued; "and that's the last I heard of it." Review of Resident #1's October 2015 Medication Administration Records (MARs) revealed there was no entry on the MAR to monitor his BMs. Review of Resident #1's November 2015 MARs revealed: - A handwritten entry to monitor BMs if patient does not have BM every day begin Miralax. - A handwritten entry for Miralax powder give 1 scoop of in 8oz. of liquid as needed if no BM every day. - Documentation Resident #1 was administered Miralax on 11/02/15 for "no BM." - There was no documentation Resident #1's BM's were monitored any other date. Review of Resident #1's December 2015 MARs revealed: - There was no entry to monitor Resident #1's BMs. - An entry for Miralax 12 grams in 8 ounces of liquid as needed if no bowel movement every day. - There was no documentation Resident #1's BMs were monitored from December 1-December 6 or received Miralax from December 1-December 6. Review of the physician's order dated 12/07/15 revealed an order to discontinue monitoring	{D 276}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 276}	Continued From page 98 Resident #1's BMs and discontinue Miralax. Interview with the Registered Nurse (RN) at Resident #1's Primary Care Physician (PCP) office on 12/14/15 at 2:50pm revealed: - Resident #1 was evaluated by the Physician Assistant (PA) on 10/30/15 for follow up to a fall. - The PA wrote an order to have Resident #1's bowel movements monitored because he was on Coumadin and had a drop in his hemoglobin and hematocrit labs. - The PA wanted to make sure Resident #1 did not have any black or tarry stools because that could be an indication of gastrointestinal bleeding. - The PA also wanted to monitor if Resident #1 had a BM every day and wrote an order for him to receive Miralax if he did not have a BM every day. - The PCP office expected the facility to monitor Resident #1's BMs daily and notify the office for any abnormal BMs. - The PCP office had not been notified Resident #1 had any abnormal BMs. - The facility contacted the PCP office regarding the orders and the orders were discontinued on 12/07/15. Refer to the interview with the Executive Director on 12/11/15 at 12:06pm. 2. Review of Resident #4's current FL-2 dated 12/04/15 revealed: - Diagnoses included atrial fibrillation, chronic venous insufficiency, peripheral vascular disease, elevated glucose, hypertension, hypothyroidism, edema, long-term anticoagulant therapy, gait disturbance, obesity, and knee pain. A. Review of Resident #4's record revealed: - There was an order from the physician dated	{D 276}			

Division of Health Service Regulation

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{D 276}	Continued From page 99 09/19/15 to apply Duoderm to Resident #4's sacral area and change Duoderm dressing every 3 days and as needed if soiled. (Duoderm is used as a dressing treatment for Stage II-IV Decubitus ulcers.) Review of Resident #4's medication administration records (MARs) for September 2015 revealed: - Duoderm was documented as applied for 8 days including 09/22, 09/23, 09/24, 09/25, 09/27, 09/28, 09/29, and 09/30. Review of Resident #4's MARs for October 2015 revealed: - Duoderm was documented as applied for 6 days including 10/16, 10/19, 10/22, 10/23, 10/25, and 10/28. Review of Resident #4's MARs for November 2015 revealed: - No documentation of Duoderm application for November 2015. Review of Resident #4's MARs for December 2015 revealed: - No documentation of Duoderm application for December 2015. Review of Resident #4's record revealed: - There was an order from the physician dated 12/04/2015 to discontinue Duoderm to sacrum. Sacral area was healed. Telephone interview with a pharmacist on 12/14/15 at 4:00 p.m. revealed: - The pharmacy had dispensed 4 boxes of Duoderm since 07/20/15. - One box with quantity of 5 on 07/20/15. - One box with quantity of 5 on 07/27/15.	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 100 - One box with quantity of 5 on 10/20/15. - One box with quantity of 5 on 11/18/15. - No Duoderm had been dispensed since 11/18/15. Interview with the Executive Director (ED) on 12/14/15 at 4:05 p.m. revealed she contacted the home health agency and they had not supplied any Duoderm for Resident #4. Interview with Resident #4 on 12/11/15 at 2:50 p.m. revealed: - He had a sore to his sacral area but it was healed now and he does not have a dressing to his sacral area anymore. - Resident #4 was unsure of the type of dressing used to his sacral area or how often it was changed by staff. - He stated the resident assistants and nurses changed the dressing to his sacral area. Interview with Resident Assistant (RA) on 12/15/15 at 9:40 a.m. revealed: - Resident #4 had received Duoderm dressing. - RA reported that she had not applied the Duoderm to the sacral wound. - RA reported she applied Endit cream to Resident #4's sacral area as needed after his incontinent change. Interview with a medication aide on 12/14/15 at 2:20 p.m. revealed: - She last saw Resident #4's sacral area on the previous night, 12/13/15. - There was a small purple spot and the resident said it burns. - She put cream on it and reported it to the HWD. Observation of Resident #4 on 12/15/14 at 10:00a.m. revealed:	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 101 - Decubitus to sacral area was healed with dry flaky skin and slight redness to both lower buttocks. Interview with Health and Wellness Director (HWD) on 12/15/15 at 12:15 p.m. revealed: - Facility staff was responsible for putting on the Duoderm dressings. - It should be documented on the MARs. - The resident scoots in the chair to get up and that friction causes the open areas. - The Duoderm does not help because it will not stay in place and it rolls up when he scoots in the chair - She did not notify the physician of any issues with the Duoderm. - She thought staff was applying the Duoderm. - She monitors the MARs and realized about 3 weeks ago they were still having issues with medications and treatments and consistency in documentation. - She stated that the documentation was missing on the MAR because the order was for the Duoderm to be used as needed for the staff at the facility. - She was unsure the last time she observed or assessed Resident #4's sacral area. - To her knowledge, it was healed and they were only putting protective cream on it currently. Refer to the interview with the Executive Director on 12/11/15 at 12:06pm. B. Review of Resident #4's record revealed: - There was an order from the physician dated 10/13/15 to weigh Resident #4 daily and fax the daily weight log to the physician weekly. Review of Resident #4's daily weight monitoring records for October 2015 revealed:	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 102 - There was no documentation of daily weights for 6 days including 10/22, 10/26, 10/27, 10/29, 10/30, and 10/31. - No reasons for the omissions were documented. - Resident #4's weight ranged from 202 lbs. to 204 lbs. Review of Resident #4's medication administration records (MARs) for October 2015 revealed: - Daily weights were not documented on the MAR from 10/01/15 through 10/31/15. - Initials noted for daily weights obtained on 10/14/15 through 10/21/15, 10/23/15 through 10/26/15, and 10/28/15 through 10/30/15. Review of Resident #4's daily weight monitoring records for November 2015 revealed: - There was no weight monitoring record for November 2015. Review of Resident #4's MARs for November 2015 revealed: - Daily weights were not documented on the MAR for 16 days including 11/4, 11/5, 11/6, 11/9, 11/10, 11/12, 11/14, 11/15, 11/16, 11/18, 11/19, 11/21, 11/22, 11/23, 11/24, and 11/30. - No reasons for the omissions were documented. - Resident #4's weight ranged from 173 lbs. to 204 lbs. Review of Resident #4's daily weight monitoring records for December 2015 revealed: - There was no documentation of daily weights for 9 days including 12/1, 12/3, 12/5, 12/6, 12/7, 12/8, 12/9, 12/10, and 12/11. - No reasons for the omissions were documented.	{D 276}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 276}	Continued From page 103 - Resident #4 ' s weight ranged from 170 lbs. to 173 lbs. Review of Resident #4's MARs for December 2015 revealed: - Daily weights were not documented on the MAR for 9 days including 12/1, 12/4, 12/5, 12/6, 12/7, 12/8, 12/9, 12/10, and 12/11. - Resident #4's weight ranged from 171 lbs. to 173 lbs. Interview with a Resident Assistant (RA) on 12/11/15 at 12:05p.m. revealed: - No daily weight had done with Resident #4 today. - They had forgotten to get the daily weight when getting Resident #4 up. Interview with Executive Director (ED) on 12/11/15 at 12:20 p.m. revealed: - She was not aware of daily weight checks missed for Resident #4 in October 2015, November 2015, and December 2015. - She did not know that daily weight had not been done for 12/11/15. - She would make sure that weight checks for Resident #4 were done. Interview with Resident #4 on 12/11/15 at 2:50 p.m. revealed: - He has his weight checked at the facility. - He was weighed on the afternoon of 12/11/15. - Resident #4 was unsure of how often his weight was checked at the facility. - He has not refused to be weighed at the facility. - Resident #4 stated, "I just don't like getting up early in the morning". Interview with Health and Wellness Director (HWD) on 12/15/15 at 9:25a.m. revealed:	{D 276}			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 276}	Continued From page 104 - Resident #4 sometimes refused to get up to have daily weights done. - The staff had not documented Resident #4's refusals of daily weights. - She was not aware that staff had reattempted to weigh Resident #4 after he got up. - The Resident Care Coordinator (RCC) was in charge of keeping up with weight monitoring records of the facility. - HWD was not aware of variation in the weights of Resident #4 for the November 2015. - HWD reported there was problem with accuracy of the chair scales used by the facility. - HWD reported that the chair scales were last serviced in July 2015. Interview with a second Resident Assistant (RA) on 12/15/15 at 9:40 a.m. revealed: - She documented the weight on the resident's MAR. - Weights are reported to the medication aide and then the medication aide reports the resident's weight to the HWD or RCC. - Resident #4 sometimes refused to get up for daily weights to be done. - RA reports to the medication aide that Resident #4 refuses to have weight done and the medication aide reports the refusal to the HWD or the RCC. - They do not document on the MAR, weight monitoring record, or in the resident note when Resident #4 refuses to have daily weights done. - Staff had not attempted to weigh Resident #4 after his refusals. Interview with Resident Care Coordinator (RCC) on 12/15/15 at 11:35a.m. revealed: - She works with the HWD to maintain weight records for residents on the weight monitoring records.	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 105 - She was not aware that Resident #4 had been refusing to have his weight checked. - There was no documentation in the records for residents refusing to have their weights checked. Interview with Resident #4's primary physician's assistant (PA) on 12/15/15 at 1:17 p.m. revealed: - Resident #4 has a current order to be weighed daily and daily log is to be faxed to the medical provider. - PA brings her own scales to weigh patient because she was aware of the inaccuracy of the facility's chair scales. - PA was unaware that Resident #4's refusals to have daily weights and no reports of weight refusal from the facility staff. - PA was not sure if weekly logs of Resident 4's weights had been faxed to their medical office. Interview with Resident #4's Family Member on 12/15/15 at 2:25 p.m. revealed: - She knew that Resident #4 was being weighed at the facility but was unsure of how often. - Family member was unaware of Resident #4's refusing to have his weight checked. Refer to the interview with the Executive Director on 12/11/15 at 12:06pm. _____ Interview with the Executive Director on 12/11/15 at 12:06pm revealed: - Physician ordered medications and treatments are transcribed on to each resident's MARs. - The Medication Aides (MAs) are responsible for initialing the MARS to document the order was administered. - If there is not a MA initial on the MAR, it	{D 276}		

Division of Health Service Regulation

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{D 276}	Continued From page 106 means the medication or treatment was not provided to the resident. _____ Review of the facility's plan of protection dated 12/11/15 revealed: - The Health and Wellness Director (HWD), Resident Care Coordinator (RCC), and/or designee will immediately begin an audit to ensure that incidental health care needs of residents have been transcribed on the MAR and have been implemented. - HWD / designee will retrain medication aides on current incidental health care needs of residents. - HWD, RCC, and/or designee will conduct random MAR and flow sheet audits 3 times a week for one month. - After one month, random weekly and prn (as needed) audits will be ongoing. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2016.	{D 276}		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the	D 280		

Division of Health Service Regulation

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D 280	Continued From page 107 following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a physical assessment and evaluation was completed for Licensed Health Professional Support (LHPS) review for 3 of 5 residents sampled (#1, #4, and #5) with required tasks including one resident with a CPAP (#1); two residents receiving physical therapy, assistance with ambulation using a walker and/or wheelchair and assistance with transfers (#4, #5); one resident with orders for oxygen and nebulizer (#5); and, one resident with dressing changes for a sacral decubitus (#4). The findings are: 1. Review of Resident #1's current FL-2 and FL-2 addendum dated 04/27/15 revealed: - Diagnoses included coronary artery disease (CAD), cardiomyopathy, atrial fibrillation with pacemaker placement, Stage III chronic kidney disease, mild cognitive impairment, benign prostate hyperplasia (BPH), history of cerebrovascular accident (CVA), and pre-diabetes. - Resident #1 was intermittently disoriented.	D 280		

Division of Health Service Regulation

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D 280	Continued From page 108 - Resident #1 was ambulatory. Review of the Resident Register revealed Resident #1 was admitted to the facility on 04/26/15. Review of the LHPS Review with date of evaluation documented as 08/14/15 revealed: - Documentation Resident #1 had a continuous positive air pressure device (CPAP). - The LHPS Review form was not signed by a licensed health professional. Review of the LHPS Review dated 10/01/15 revealed: - Resident #1 had CPAP and required assistance using a walker. - There were no additional tasks documented on the LHPS review. - The LHPS Review was signed by the Health and Wellness Director (HWD). Review of Resident #1's record revealed there were no additional LHPS Reviews. Observation on 12/11/15 at 3:00 pm revealed Resident #1 had a CPAP (continuous positive air pressure) machine in his room beside his bed. (CPAP is a device that uses mild air pressure to keep the airways open. CPAP typically is used by people who have breathing problems, such as sleep apnea). Review of Resident #1's record revealed a physician order dated 10/12/15 for Resident #1 to self-administer his CPAP. Interview with Resident #1 on 12/1/5/15 at 09:50am revealed: - Resident #1 had a CPAP.	D 280		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 280	Continued From page 109 - Resident #1 did not wear his "breathing machine last night." - Resident #1 could not remember the last time he wore the CPAP but it helped him "sleep better." - Resident #1 stated "I don't know if I can get it [CPAP] on without help." Review of Resident #1's "Personal Service Plan"/Care Plan (PSP/CP) 05/14/15 revealed: - "CPAP at bedtime." - "Resident is independent with using oxygen or respiratory equipment." - The PSP/CP was signed by the HWD and dated 05/14/15. Review of Resident #1's most current PSP/CP dated 11/09/15 revealed: - "Uses CPAP or BiPAP." - "CPAP at bedtime." - "Resident is independent with using oxygen or respiratory equipment." - The PSP/CP was signed by the HWD and dated 11/18/15. Confidential staff interview revealed: - Resident #1 does not use his CPAP device "too often." - When Resident #1 used his CPAP he required assistance from staff. Telephone interview with Resident #1's family member/Power of Attorney (POA) on 12/11/15 at 12:39pm revealed: - Resident #1 had a CPAP device. - Resident #1 did not use his CPAP and had not used it for "awhile." - The POA did not know if Resident #1 would be able to use the CPAP independently at this time.	D 280		

Division of Health Service Regulation

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D 280	Continued From page 110 - "They would give him help (with the CPAP), but it would cost \$400.00 more a month so he refuses it." - The Health and Wellness Director (HWD) was aware Resident #1 refused his CPAP because it was discussed when she "increased" his care plan in November 2015. Interview with the HWD on 12/15/15 at 10:55am revealed: - Resident #1 had a CPAP device. - Resident #1 had a physician order to use the CPAP independently. - The HWD had not assessed Resident #1's use of the CPAP independently but he had used it "at home" independently. Interview with the Executive Director on 12/15/15 at 11:15am revealed: - Resident #1 had a CPAP device which he used independently. - Resident #1 had a physician order to use his CPAP independently. - "As far as I know" the HWD assessed Resident #1 to assure he could "self-administer." - The ED had no knowledge of Resident #1's noncompliance with his CPAP device. Refer to interview with Health and Wellness Director (HWD) on 12/15/15 at 12:15p.m. Refer to interview with HWD on 12/15/15 at 4:55 p.m. Refer to interview with the Executive Director (ED) on 12/14/15 at 4:27 p.m. Refer to interview with the ED on 12/15/15 at 4:10 p.m.	D 280		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 280	Continued From page 111 2. Review of Resident #4's current FL-2 dated 12/04/15 revealed: - Diagnoses included atrial fibrillation, chronic venous insufficiency, peripheral vascular disease, elevated glucose, hypertension, hypothyroidism, edema, long-term anticoagulant therapy, gait disturbance, obesity, and knee pain. - Resident is semi-ambulatory and uses a walker and a wheelchair for assistance with ambulation. Review of Resident #4's Resident Register revealed: - He was admitted to the facility on 11/17/14. - The resident needed assistance with dressing, bathing, ambulation, getting in and out of bed, toileting, skin care, and scheduling appointments. - The resident was forgetful and needed reminders. - The resident had a walker. Review of Licensed Health Professional Support (LHPS) review with an evaluation dated of 12/09/14 revealed: - Documentation that Resident #4 had PT/INR checked per MD office. - Resident #4 was unsteady when bending over or changing positions. - Resident #4 requires assist with dressing, showering, and medication management. - The LHPS Review was signed by the Health and Wellness Director (HWD). Recommended changes and Follow-up Recommended to meet the Needs of Resident #4 documented on the LHPS dated 12/09/14 included: - Staff to encourage Resident #4's participation in community activities. - Staff to monitor for signs and symptoms of bleeding - Staff to monitor for changes in mentation and	D 280		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 280	Continued From page 112 ability to assist in activities of daily living (ADLs). - Notify physician as appropriate. Review of Resident #4's Licensed Health Professional Support (LHPS) review dated 12/09/14 revealed: - PT/INR checks were discontinued 01/21/15. - Documentation dated 03/12/15 at the bottom of the page stated "No changes" and was signed by the HWD. - Documentation dated 06/11/15 at the bottom of the page stated "No changes" and was signed by the HWD. - Documentation dated 09/19/15 at the bottom of the page stated "No changes" and was signed by the HWD. - No LHPS reviews that were done after 01/21/15 included reviews of health status and care provided, physical assessment related to current diagnoses, or updates to progress to care provided. Review of Resident #4's care plan dated 08/05/15 revealed: - Resident #4 is semi-ambulatory and uses a walker for assistance with ambulation. - Resident #4 uses a wheelchair on occasion. - Resident required physical assistance with dressing and grooming related to balance/coordination issues. - Resident #4 required the assistance of 2 people to assist to a standing position from bed, chair, or lift chair. - Resident #4 had multiple falls in the last 12 months related to decreased safety awareness and resident getting up without assistance. Review of Resident #4's record revealed: - An order from the medical provider dated 09/19/15 to apply Duoderm to Resident #4's	D 280		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 280	Continued From page 113 sacral area and change Duoderm dressing every 3 days and as needed if soiled (Duoderm is used as a dressing treatment for Stage II-IV Decubitus ulcers). - An order from the physician for physical therapy to evaluate and treat dated 10/12/15. - An order from the physician for a wheelchair dated 10/30/15. - An order from the physician dated 12/04/15 to discontinue Duoderm dressing to sacral area of Resident #4 because the area was healed. Review of accident/incident reports, shift notes, and communication notes for Resident #4 revealed a total of 13 reported falls from 09/27/15 to 11/27/15. Observation and interview of Resident #4 on 12/10/15 at 11:09 a.m. revealed: - Resident was sitting in lift chair with feet elevated and his walker was within reach. - Resident stated, "I would walk you to the door if I could get up". - Resident reported he had "quite a few falls". - Resident was currently receiving physical therapy. - Resident stated that he is able to stand up independently using his lift chair to assist him. - Resident #4 stated that he does use his call bell to call staff for assistance if needed. Interview with Resident #4 on 12/11/15 at 2:50 p.m. revealed: - Resident stated that he had fallen several times over the last few months. - Resident reported that when he falls he just loses his balance and falls over. - Resident uses a walker for assistance with ambulation. - Resident reported that he has a wheelchair but	D 280			

Division of Health Service Regulation

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D 280	Continued From page 114 does not like to use it. - Resident had a lift chair in his room to assist him to stand and he was able to use the lift chair without assistance. Interview with Resident Assistant (RA) on 12/15/15 at 9:40 a.m. revealed: - Staff is available to help residents get up in the morning and staff checks on residents throughout the day. - RA voiced concerns regarding Resident #4's frequent falls. - Resident #4 falls a lot because the resident forgets to use the call bell to ask for help. - Resident #4's falls are mainly when the resident was trying to get to the bathroom. - Resident #4 had a Stage II decubitus to sacral area that is not healed. Interview with Health and Wellness Director (HWD) on 12/15/15 at 12:15p.m. revealed: - Resident #4 requires assistance with transfers and ambulation and he had a wound recently. - The resident has had therapy after therapy for his falls. - The resident is currently getting physical therapy. - HWD reported she documented on LHPS reviews that Resident #4 had no LHPS tasks but she could not explain why. - Resident #4 had LHPS tasks and LHPS reviews should have been done. - HWD stated, "I dropped the ball on it" when referring to completing LHPS reviews for Resident #4. Interview with Resident #4's family member on 12/15/15 at 2:25 p.m. revealed: - Family member stated that Resident #4 brought his lift chair with him when he came to the facility	D 280		

Division of Health Service Regulation

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D 280	Continued From page 115 in 11/2014. - Resident #4 used the lift chair to assistance him to stand. - Family member was concerned with resident's balance and feels like if he doesn't have someone to help him get up then he falls. - Family member stated that Resident has had several problems with sores to his sacral area since this past summer. - Family member stated that Duoderm had been used to wound to Resident #4's sacral previously but area is now healed. Refer to interview with Health and Wellness Director (HWD) on 12/15/15 at 12:15p.m. Refer to interview with HWD on 12/15/15 at 4:55 p.m. Refer to interview with the Executive Director (ED) on 12/14/15 at 4:27 p.m. Refer to interview with the ED on 12/15/15 at 4:10 p.m. 3. Review of Resident #5's current FL-2 dated 03/30/15 revealed: - Diagnoses included chronic obstructive pulmonary disease, hypertension, cerebrovascular accident, congestive heart failure, coronary artery disease, acute respiratory failure, chronic respiratory failure, history of acute renal failure, skin cancer, dysphonia, constipation, and dysphagia. - Resident is semi-ambulatory and used a walker and a wheelchair for assistance with ambulation. Review of Resident Register revealed Resident #5 was admitted to the facility on 12/23/13. - Review of Resident #5's record revealed: - There was an order from the physician dated	D 280		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 280	Continued From page 116 01/02/15 for Resident #5 to receive physical therapy. - There was an order from the physician dated 03/30/15 for Resident #5 to oxygen via nasal cannula at 2 liters per minute. - There was an order from the physician dated 03/30/15 for Resident #5 to receive DuoNeb breathing treatments via nebulizer 4 times daily as needed for shortness of breath and cough. - There was an order from the physician dated 03/30/15 for Resident #5 was semi-ambulatory and used a walker and wheelchair for mobility. Review of Licensed Health Professional Support Review with an evaluation dated 06/11/15 revealed: - Resident #5 was on oxygen at 2 liter per minute via nasal cannula. - Resident #5 received physical therapy. - Resident #5 required a one person assist with transfers. - Resident #5 was wheelchair dependent related to respiratory status. - Resident #5 required an escort throughout the facility to use his wheelchair. - Resident #5 continued the need for DuoNeb breathing treatments four times a day as needed. - The LHPS Review was signed by the Health and Wellness Director (HWD). Recommended changes and Follow-up Recommended to meet the Needs of Resident #5 documented on the LHPS dated 06/11/15 included: - Staff to monitor for signs and symptoms of congestive heart failure. - Staff to provide reassurance that oxygen is operated correctly. - Staff to report changes to family and physician as appropriate	D 280		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 280	Continued From page 117 Review of Resident #5's Licensed Health Professional Support (LHPS) review dated 06/11/15 revealed: - Documentation dated 09/19/15 at the bottom of the page stated "No changes" and was signed by the HWD. - Documentation dated 12/08/15 at the bottom of the page stated "No changes" and was signed by the HWD. - There were no LHPS reviews that were done after 06/11/15 which included reviews of health status and care provided, physical assessment related to current diagnoses, or updates to progress to care provided. Review of Resident #5's care plan dated 08/05/15 revealed: - Resident #5 is semi-ambulatory, used a walker for assistance with ambulation, or wheelchair for mobility. - Resident #5 required physical assistance with grooming, ambulation, and toileting. - Resident #5 required extensive physical assistance with bathing and dressing. - Resident #5 required supervision with transferring. Observation and interview of Resident #5 on 12/10/15 at 3:50p.m. revealed: - Resident was alert and oriented to person, place, and time. - Resident used wheelchair primarily for mobility throughout the facility. - Resident used wheelchair independently but sometimes needed assistance with his wheelchair if he was short of breath. - Resident reported that he receives physical therapy two times a week. - Resident had oxygen via nasal cannula at 2 liters per minute.	D 280		

Division of Health Service Regulation

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D 280	Continued From page 118 - Resident reported that he needed assistance with bathing, grooming, dressing, transferring, and toileting. - Resident had no edema to lower extremities, abdomen, or neck. - Resident reported that he received his Duoneb treatment primarily in the morning. Refer to interview with Health and Wellness Director (HWD) on 12/15/15 at 12:15p.m. Refer to interview with HWD on 12/15/15 at 4:55 p.m. Refer to interview with the Executive Director (ED) on 12/14/15 at 4:27 p.m. Refer to interview with the ED on 12/15/15 at 4:10 p.m. _____ Interview with Health and Wellness Director (HWD) on 12/15/15 at 12:15p.m. revealed: - HWD was responsible for completing LHPS evaluations, LHPS reviews, and care plans for all residents. - HWD reported that she does LHPS reviews quarterly for each resident and maintains a schedule to complete the LHPS reviews. - She had no explanation for the LHPS reviews not being completed as required. Interview with the HWD on 12/15/15 at 4:55 p.m. revealed: - She was trained to document "no changes" instead of completing a new LHPS review form. - No actual physical assessments were done for any LHPS re-evaluations. - She was trained that LHPS reviews only included the review of LHPS tasks and no	D 280			

Division of Health Service Regulation

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D 280	Continued From page 119 physical assessments were needed. Interview with the Executive Director (ED) on 12/14/15 at 4:27 p.m. revealed a new form should be filled out each time for the LHPS reviews because of the physical assessment required with each review. Interview with the Executive Director (ED) on 12/15/15 at 4:10pm revealed: - The HWD is responsible for completing LHPS Review for all residents. - The ED maintained a list of LHPS Review tasks with due dates. - The ED was unsure why the LHPS Reviews had not been completed for the residents' required tasks.	D 280			
{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: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observation, interview, and record review, the facility failed to assure medications	{D 358}			

Division of Health Service Regulation

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{D 358}	Continued From page 120 were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 4 of 13 residents (#2, #6, #7, #8) observed during the medication passes, including errors with insulin, oral diabetes medication, inhaler for breathing problems, and a medication used to treat and prevent stomach ulcers and 1 of 6 residents (#8) sampled for record review related to errors with sliding scale insulin. The findings are: 1. The medication error rate was 13% as evidenced by the observation of 4 errors out of 30 opportunities during the 4:00 p.m. - 5:00 p.m. medication pass on 12/10/15 and the 8:00 a.m. and 11:30 a.m. medication passes on 12/11/15. A. Review of Resident #8's current FL-2 dated 10/22/15 revealed diagnoses included diabetes with renal manifestations, hypertension, chronic obstructive pulmonary disease, hyperlipidemia, hypothyroidism, and insomnia. Review of a physician's order for Resident #8 dated 10/26/15 revealed: - There was an order for fingerstick blood sugars (FSBS) 4 times a day before meals and at bedtime. - There was an order for Humalog insulin 15 minutes prior to meals as follows: <80 = call physician; 81 - 125 = no insulin; 126 - 150 = 3 units; 151 - 200 = 4 units; 201 - 250 = 5 units; 251 - 300 = 6 units; 301 - 350 = 7 units; 351 - 400 = 8 units; >401 = 9 units and call physician. (Humalog is a rapid-acting insulin that lowers blood sugar. The manufacturer recommends Humalog be given within 15 minutes before a meal or immediately after a meal.) Observation of the medication office on 12/11/15	{D 358}		

Division of Health Service Regulation

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{D 358}	Continued From page 121 at 11:30 a.m. revealed: - The day shift (7am - 7pm) medication aide was in the office and stated she was about to check Resident #8's FSBS and administer his insulin. - The Health and Wellness Director (HWD) was in the medication office and heard the medication aide say she was going to Resident #8's room for his lunchtime FSBS and insulin. Observation of the medication pass on 12/11/15 at 11:30 a.m. revealed: - The medication aide checked Resident #8's FSBS at 11:35 a.m. and it was 180. - The medication aide told the resident he would get 4 units of Humalog insulin for the sliding scale. - The resident told the medication aide that his insulin order changed the previous day when he went to the endocrinologist's office. - The resident said he had spoken to the HWD about the insulin change that morning on 12/11/15. - The resident said he should get 5 units of insulin with the new sliding scale order. - The medication aide told the resident she had not received a new order yet and she would administer the insulin according to the order on the MAR. - The medication aide administered 4 units of Humalog insulin to the resident at 11:37 a.m. Observation on 12/11/15 revealed: - Resident #8 was served lunch at 12:15 p.m., 38 minutes after he received the insulin. - The insulin was not administered 15 minutes prior to the meal as ordered. Interview with the day shift medication aide on 12/11/15 at 11:40 a.m. revealed: - Resident #8 returned to the facility around 6:50	{D 358}		

Division of Health Service Regulation

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{D 358}	Continued From page 122 p.m. on 12/10/15 near shift change (7pm). - She thought the night shift (7pm - 7am) medication aide talked with the resident's family member about medication order changes. - The night shift medication aide told her this morning during shift change (7am) on 12/11/15 that there were some order changes for Resident #8 but she did not have the orders yet. - She did not report this information to anyone. - She thought the HWD had the orders currently. - She usually started her lunchtime medication pass at 11:30 a.m. with the insulin for Resident #8. - Lunch was usually served at 12:00 noon. Interview with the Health and Wellness Director / Registered Nurse (HWD) on 12/11/15 at 11:42 a.m. revealed: - Resident #8 went to a doctor's appointment with his family yesterday on 12/10/15. - The resident returned to the facility last night but she was not at the facility when the resident returned. - The resident just brought some orders to the HWD a few minutes ago that morning (could not say specific time) on 12/11/15. - She had not implemented the orders yet because she had not had a chance to check over the orders. - They will start the new orders at the next scheduled dosing time. - If a resident went to an appointment, the resident was supposed to give any orders to the medication aide on duty when the resident returns to the facility. - She did not realize the resident had new orders until the resident came to her that morning. - The resident wanted to give the orders to the HWD. - She had not checked with the resident about	{D 358}		

Division of Health Service Regulation

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{D 358}	Continued From page 123 his appointment on the previous day until he came to her with the order changes that morning on 12/11/15. Review of an order from the Nurse Practitioner from an endocrinology office dated 12/10/15 revealed: - There was an order to increase the Humalog insulin to: 81 - 125 = no insulin; 126 - 150 = 4 units; 151 - 200 = 5 units; 201 - 250 = 6 units; 251 - 300 = 7 units; 301 - 350 = 8 units; 351 - 400 = 9 units; > 401 = 10 units and call the physician. Review of the December 2015 medication administration record (MAR) on 12/11/15 at 11:45 a.m. revealed: - The order for Humalog sliding scale insulin dated 10/26/15 was printed on the MAR. - The order dated 12/10/15 to increase the Humalog insulin had not been transcribed onto the MAR. Interview with Resident #8 on 12/11/15 at 2:58 p.m. revealed: - His blood sugar had been running a little high. - He was seen at his endocrinologist's office yesterday on 12/10/15. - His insulin dosage was increased. - When he returned from the appointment on the evening of 12/10/15, he told the medication aide his insulin orders had changed. - The medication aide told the resident to wait and give the orders to the HWD. - The medication aide told the resident she could not change the orders until the HWD checked the orders. - He gave the paperwork with the orders to the HWD this morning around 10:00 a.m. - They have not started the new orders yet.	{D 358}		

Division of Health Service Regulation

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{D 358}	Continued From page 124 Interview with the day shift medication aide on 12/11/15 at 3:10 p.m. revealed: - Resident #8 mentioned to her this morning before breakfast that his insulin order had changed. - She told the resident that she did not have the order so she could not change it. - She did not notify the HWD of the new order mentioned by the resident. - The medication aide on duty when an order is received was responsible for implementing new orders. - The medication aides do not have to wait for the HWD to check orders before they can implement the orders. Interview with the Executive Director (ED) on 12/11/15 at 12:50 p.m. revealed: - The medication on duty is responsible for getting any paperwork, including orders, when a resident returns from an appointment. - The medication aide on duty when Resident #8 returned from his appointment on 12/10/15 asked for the folder but the resident told her that he wanted to give it to the nurse. - The Humalog insulin should have been administered within 15 minutes prior to the meal as ordered. Telephone interview with the night shift medication aide on 12/14/15 at 2:20 p.m. revealed: - She was working the evening of 12/10/15 when Resident #8 returned to the facility with a family member. - She did not know the resident had gone to a doctor's appointment that day. - She thought he had been on a visit with family. - The family member told her that Resident #8 had some insulin changes and he was going to	{D 358}			

Division of Health Service Regulation

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{D 358}	Continued From page 125 go over them with the HWD in the morning. - The medication aide on duty was responsible for implementing new orders. - She thought since the resident was on sliding scale insulin, it may be difficult. - She did not ask the resident to see the orders. - The next morning on 12/11/15 before she left the facility (shift ends at 7am), she let the ED know about the order changes. Interview with the ED on 12/14/15 at 4:33 p.m. revealed: - When the ED came into the facility around 7:00 a.m. on Friday, 12/11/15, the medication aides told the ED the resident came back with new orders the previous day. - The medication aides reported the resident would only give the orders to the nurse (HWD). - She did not relay the information about the orders to the HWD because the ED thought the medication aides would tell the HWD. Review of the November 2015 and December 2015 blood sugar monitoring forms for Resident #8 revealed: - His FSBS ranged from 45 - 511 from 11/01/15 - 11/30/15. - His FSBS was 211 - 295 on 20 occasions in 11/2015. - His FSBS was 306 - 395 on 20 occasions in 11/2015. - His FSBS was 420 - 469 on 4 occasions in 11/2015. - His FSBS ranged from 57 - 472 from 12/01/15 - 12/15/15. - His FSBS was 203 - 296 on 24 occasions from 12/01/15 - 12/15/15. - His FSBS was 306 - 387 on 7 occasions from 12/01/15 - 12/15/15. - His FSBS was 400 - 472 on 2 occasions from	{D 358}		

Division of Health Service Regulation

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{D 358}	Continued From page 126 12/01/15 - 12/15/15. B. Review of Resident #2's current FL-2 dated 10/21/15 revealed: - Diagnoses included asthma, congestive heart failure, muscle weakness, difficulty walking, closed fracture of 3 ribs, essential hypertension, pure hypercholesterolemia, and osteoporosis. - There was an order for Albuterol inhaler, inhale 2 puffs 4 times a day. (Albuterol is used to acute lung/breathing problems.) Review of the December 2015 medication administration record (MAR) revealed: - There was an entry for Albuterol inhale 2 puffs 4 times daily. - Albuterol was scheduled to be administered at 8:00 a.m., 12:00 noon, 4:00 p.m., and 8:00 p.m. Observation of the medication pass on 12/10/15 revealed: - The medication aide administered 2 quick puffs in a row of Albuterol to Resident #2 at 4:59 p.m. - The medication aide did not instruct the resident to inhale the medication when the inhaler was pressed down nor to hold breath in for approximately 10 seconds to allow the medication to reach the lungs. - The medication aide did not wait one minute between puffs. (Waiting one minute between puffs may permit additional puffs to penetrate the lungs better.) - The resident did not inhale the medication and the medication vapors came back out of the resident's mouth from both puffs. Interview with the medication aide on 12/10/15 at 5:50 p.m. revealed: - She stated that was how she usually did the resident's inhaler.	{D 358}			

Division of Health Service Regulation

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{D 358}	Continued From page 127 - She knew she was supposed to wait one minute between puffs. - She did not know why she did not wait between the puffs today. - She sometimes saw the medication vapors come back out of the resident's mouth. Interview with the Health and Wellness Director / Registered Nurse (HWD) on 12/10/15 at 6:00 p.m. revealed: - Medication staff have been trained on proper technique for administration of inhalers. - Staff should instruct the resident to take a deep breath in and to wait between the puffs. Review of Resident Log notes for Resident #2 revealed: - 12/11/15 (3:30 p.m.): HWD was called to the resident's room to assist with transfer. Resident stated she wasn't feeling well and was breathing heavily after transfer. Resident was given her Albuterol inhaler and within 5 minutes the resident was back to normal. - 12/11/15 (9:15 p.m.): Resident was sent to the hospital wheezing, breathing got worse. - 12/12/15 (11:00 a.m.): Spoke with nursing staff at hospital. Resident was admitted for deep vein thrombosis (DVT) and possible pneumonia. Review of a hospital history and physical form dated 12/15/15 revealed: - Resident #2 was admitted to the hospital on 12/12/15 and was still currently hospitalized. - Resident presented with healthcare associated pneumonia and acute DVT. - The assessment and plan included: acute DVT (blood clot) of the left femoral vein; chronic obstructive pulmonary disease exacerbation; possible diastolic congestive heart failure; and hypertension.	{D 358}		

Division of Health Service Regulation

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{D 358}	Continued From page 128 C. Review of Resident #6's current FL-2 dated 08/03/15 revealed: - Diagnoses included non-insulin dependent diabetes mellitus, chronic kidney disease stage III, hypertension, peripheral joint disease of knee and leg, deep vein thrombosis, pulmonary embolism, constipation, depression, hypothyroidism, osteoporosis, Alzheimer's dementia, and allergic rhinitis. - There was an order for Metformin 500mg 1 twice daily, take with food. (Metformin is used to treat diabetes and lowers blood sugar. It is recommended to be taken with food to avoid stomach irritation.) Review of the December 2015 medication administration record (MAR) revealed: - Metformin was scheduled to be administered at 8:00 a.m. and 5:00 p.m. - Instructions printed on the MAR included, "Take with Food". Observation of the 5:00 p.m. medication pass on 12/10/15 revealed: - Resident #6 was in the common living room area outside of the dining room. - The resident was agitated, pacing back and forth to the locked front door. - Staff redirected the resident away from the door. - Metformin was administered to the resident at 4:58 p.m. - The medication aide did not offer any food with the resident's medication - She did not ask the resident if she was going to eat supper. Observation of the dining room and living room area on 12/10/15 revealed:	{D 358}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 358}	Continued From page 129 - Staff began serving food to the residents in the dining room at 5:15 p.m. - Resident #6 was not in the dining room. - Resident #6 was in the living room area with staff. - Staff asked the resident if she was going in the dining room. - The resident did not want to go in the dining room. - Staff did not offer Resident #6 food/snack. Based observation and interview, Resident #6 was confused and not interviewable. Interview with the medication aide on 12/10/15 at 5:50 p.m. revealed: - She usually started her medication pass at 4:30 p.m. - She would usually try to give medications ordered with food or meals at the table with the meal. - Supper was usually served at 5:00 p.m. - She had not noticed the instructions to give the Metformin with food. Interview with the Health and Wellness Director / Registered Nurse (HWD) on 12/10/15 at 6:00 p.m. revealed: - The facility's policy was to give medications ordered with food with the meal or with a snack. - It should be given with the first bite of food up to 30 minutes after the meal. Observation of Resident #6 on 12/10/15 at 6:15 p.m. revealed she as still sitting in the living room and had not gone into the dining room to eat. D. Review of Resident #7's current FL-2 dated 11/10/15 revealed: - Diagnoses included dementia, hypertension, paroxysmal atrial fibrillation, coronary artery	{D 358}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 358}	Continued From page 130 disease, cellulitis of right upper limb, deep vein thrombosis, chronic anemia, and history of lung cancer. - There was an order for Carafate 1gm/10ml suspension 10ml by mouth 4 times a day before meals and at bedtime. (Carafate is used to treat and prevent stomach ulcers. It should be taken on an empty stomach in order for the medication to coat the stomach to exert its effect.) Review of the December 2015 medication administration record (MAR) revealed: - There was an entry for Carafate 10ml 4 times a day before meals and at bedtime. - Carafate was scheduled to be administered at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. Observation of the morning medication pass on 12/11/15 revealed: - The medication aide administered Carafate to Resident #7 at 7:59 a.m. with his other oral pill scheduled at 8:00 a.m. - Resident was in the dining room and had eaten all of his breakfast except for ¼ slice of toast. - Carafate was not administered on an empty stomach before the meal as ordered. Interview with the medication aide on 12/11/15 at 9:10 a.m. revealed: - Breakfast was usually served at 7:00 a.m. - She usually gave the resident his morning medications before he ate breakfast. - She was running behind with her medication pass this morning. Interview with Resident #7 on 12/11/15 at 9:20 a.m. revealed: - The resident thought he usually got the pink liquid medication (Carafate) before he eats. - He thought the staff were just busy this	{D 358}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 358}	Continued From page 131 morning. - He denied any gastrointestinal symptoms. Interview with the Health and Wellness Director / Registered Nurse (HWD) on 12/11/15 at 10:15 a.m. revealed medications ordered before meals should be given 30 minutes prior to eating. Interview with the Executive Director (ED) on 12/11/15 at 10:33 a.m. revealed medications ordered before meals should be given prior to the meal. 2. Review of Resident #8's current FL-2 dated 10/22/15 revealed diagnoses included diabetes with renal manifestations, hypertension, chronic obstructive pulmonary disease, hyperlipidemia, hypothyroidism, and insomnia. Review of a physician's order for Resident #8 dated 10/26/15 revealed: - There was an order for fingerstick blood sugars (FSBS) 4 times a day before meals and at bedtime. - There was an order for Humalog insulin 15 minutes prior to meals as follows: <80 = call physician; 81 - 125 = no insulin; 126 - 150 = 3 units; 151 - 200 = 4 units; 201 - 250 = 5 units; 251 - 300 = 6 units; 301 - 350 = 7 units; 351 - 400 = 8 units; >401 = 9 units and call physician. (Humalog is a rapid-acting insulin that lowers blood sugar.) Review of the November 2015 medication administration record (MAR) revealed: - The Humalog sliding scale was printed according to the order dated 10/26/15. - The Humalog was scheduled to be administered based on FSBS at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 10:00 p.m.	{D 358}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 358}	Continued From page 132 - The wrong dosage of Humalog sliding scale insulin was documented as administered on 11 occasions from 11/01/15 - 11/30/15. - 11/04/15 (11:30 a.m.) - FSBS was 250 and 4 units were documented but 5 units ordered. - 11/12/15 (4:30 p.m.) - FSBS was 78 and 7 units were documented but 0 units ordered. - 11/13/15 (4:30 p.m.) - FSBS was 249 and 6 units were documented but 5 units ordered. - 11/15/15 (4:30 p.m.) - FSBS was 420 and 4 units were documented but 9 units ordered. - 11/18/15 (7:30 a.m.) - FSBS was 332 and 4 units were documented but 7 units ordered. - 11/18/15 (11:30 a.m.) - FSBS was 380 and 4 units were documented but 8 units ordered. - 11/18/15 (10:00 p.m.) - FSBS was 302 and 8 units were documented but 7 units ordered. - 11/19/15 (7:30 a.m.) - FSBS was 162 and no units were documented but 4 units ordered. - 11/19/15 (4:30 p.m.) - FSBS was 142 and 4 units were documented but 3 units ordered. - 11/22/15 (4:30 p.m.) - FSBS was 469 and 8 units were documented but 9 units ordered. - 11/28/15 (7:30 a.m.) - FSBS was 175 and 3 units were documented but 4 units ordered. - The resident's FSBS ranged from 45 - 511 from 11/01/15 - 11/30/15. Review of the December 2015 MAR revealed: - The Humalog sliding scale was printed according to the order dated 10/26/15. - The Humalog was scheduled to be administered based on FSBS at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m. - The wrong dosage of Humalog sliding scale insulin was documented as administered on 9 occasions from 12/01/15 - 12/10/15. - 12/01/15 (11:30 a.m.) - FSBS was 306 and 8 units were documented but 7 units ordered. - 12/02/15 (7:30 a.m.) - FSBS was 136 and 4	{D 358}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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{D 358}	Continued From page 133 units were documented but 3 units ordered. - 12/02/15 (8:00 p.m.) - FSBS was 292 and 4 units were documented but 6 units ordered. - 12/03/15 (11:30 a.m.) - FSBS was 258 and 5 units were documented but 6 units ordered. - 12/03/15 (4:30 p.m.) - FSBS was 269 and 5 units were documented but 6 units ordered. - 12/07/15 (11:30 a.m.) - FSBS was 170 and 6 units were documented but 4 units ordered. - 12/07/15 (4:30 p.m.) - FSBS was 296 and 4 units were documented but 6 units ordered. - 12/09/15 (4:30 p.m.) - FSBS was 349 and 6 units were documented but 7 units ordered. - 12/09/15 (8:00 p.m.) - FSBS was 400 and 4 units were documented but 8 units ordered. - The resident's FSBS ranged from 57 - 472 from 21/01/15 - 12/10/15. Review of an order from the Nurse Practitioner from an endocrinology office dated 12/10/15 revealed: - There was an order to increase the Humalog insulin to: 81 - 125 = no insulin; 126 - 150 = 4 units; 151 - 200 = 5 units; 201 - 250 = 6 units; 251 - 300 = 7 units; 301 - 350 = 8 units; 351 - 400 = 9 units; > 401 = 10 units and call the physician. Interview with Resident #8 on 12/11/15 at 2:58 p.m. revealed: - They check his blood sugar 4 times a day and he gets sliding scale insulin 4 times a day if needed. - His blood sugar had been running a little high. - He was seen at his endocrinologist's office yesterday on 12/10/15. - His insulin dosage was increased. Interview with a medication aide on 12/15/15 at 3:30 p.m. revealed: - They document the amount of insulin	{D 358}		

Division of Health Service Regulation

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{D 358}	Continued From page 134 administered for the sliding scale on the MAR. - They should follow the sliding scale printed on the MAR. - She was unsure why some of the amounts of insulin documented as administered did not match the sliding scale ordered. Interview with the Executive Director (ED) on 12/15/15 at 4:10 p.m. revealed: - The medication aides have been trained to give the insulin according to the sliding scale. - The MARs should be checked by the Health and Wellness Director during random chart audits. - The ED was unaware of the errors with Resident #8's sliding scale insulin.	{D 358}		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential	D 482		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 482	Continued From page 135 decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure physical restraints, including an unplugged lift chair and recliner, were used only after an assessment and care planning process had been completed and used only after alternatives had been tried and a physician's order obtained for 1 of 1 residents (#4) sampled with restraints. The findings are: Review of Resident #4's current FL-2 dated 12/04/15 revealed:	D 482			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 482	Continued From page 136 - Diagnoses included atrial fibrillation, chronic venous insufficiency, peripheral vascular disease, elevated glucose, hypertension, hypothyroidism, edema, long-term anticoagulant therapy, gait disturbance, obesity, and knee pain. -Resident is semi-ambulatory and uses a walker and a wheelchair for assistance with ambulation. Review of Resident #4's Resident Register revealed: - He was admitted to the facility on 11/17/14. - The resident needed assistance with dressing, bathing, ambulation, getting in and out of bed, toileting, skin care, and scheduling appointments. - The resident was forgetful and needed reminders. - The resident had a walker. Review of Resident #4's assessment and care plan dated 08/05/15 revealed: - The resident required physical assistance with dressing and grooming related to balance and coordination issues. - It requires 2 staff to assist the resident to a standing position from bed or chair. - The resident was able to sit up with assistance of 2 persons using his lift chair. - He was able to stand / walk independently with walker after he is in standing position. Observation and interview of Resident #4 on 12/10/15 at 11:09 a.m. revealed: - Resident was sitting in lift chair with feet elevated and his walker was within reach. - Resident's call bell was within reach. - Resident stated, "I would walk you to the door if I could get up". - Resident reported he had "quite a few falls". - Resident was currently receiving physical therapy.	D 482			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 482	Continued From page 137 Review of accident/incident reports, shift notes, and communication notes revealed Resident #4 had a total of 13 reported falls from 09/27/15 to 11/27/15. Review of Post-Fall Investigation forms for Resident #4 revealed: - 10/06/15 - Safety interventions included: Staff to educate resident on the use of their emergency call system; staff to remind resident to use assistive devices. - 10/13/15 - Safety interventions included: Staff to educate resident on the use of their emergency call system; staff to remind resident to use assistive devices; staff to call medical doctor for PT/OT evaluation. - 10/15/15 - Safety interventions included: Staff to educate resident on the use of their emergency call system; staff to remind resident to use assistive devices; increased frequency of monitoring; staff to call medical doctor to come see the resident. - 11/07/15 - Safety interventions included: Staff to educate resident on the use of their emergency call system; staff to remind resident to use assistive devices; increased frequency of monitoring; PT/OT evaluation. Review of a primary care provider (PCP) note dated 10/16/15 revealed: - The resident was being seen for follow-up after falls. - The resident has had multiple falls over the past couple of months. - The resident is currently using a walker and states he does not want to use the wheelchair. - He also uses a lift chair however, apparently the staff were trying to keep this unplugged because they thought it was contributing to his	D 482		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 482	Continued From page 138 falls. - The resident has poor balance and slow movement. - Per chart, on 11/24/15 staff decided to leave lift chair unplugged due to falls. - On 11/27/15 the resident had a fall with no injury. - PCP discussed with resident the importance of using the wheelchair. - PCP suspects Parkinson's and gave order for follow-up in 4 weeks for neuro exam to rule out Parkinson's. Review of a memo dated 11/27/15 and written by the HWD revealed: - Please keep Resident #4's lift chair "UNPLUGGED" unless staff is with him during use. - Make sure it is unplugged when you leave his room, and that his call bell is where he can reach it. - He has had numerous falls related to that chair. - Let's see if this will make a difference. Interview with Resident #4 on 12/11/15 at 2:50 p.m. revealed: - He had fallen several times over the last few months. - When he falls he just loses his balance and falls over. - Resident uses a walker for assistance with ambulation. - He has a wheelchair but does not like to use it. - Resident had a lift chair in his room to assist him to stand and he was able to use the lift chair without assistance. - The lift chair was removed 12/10/15 and replaced with a recliner. - He was upset because his lift chair was taken away because the staff in the facility told his	D 482		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 482	Continued From page 139 family it was a fall hazard. - He never had a fall using his lift chair - He was unable to get out of recliner without assistance. - He stated that staff usually comes around about every 2 hours to check on him. - He stated that he uses his call bell if he needs assistance. - He stated that it usually takes staff about 15 - 20 minutes to answer his call bell. Interview with Resident Assistant (RA) on 12/15/15 at 9:40 a.m. revealed: - Staff is available to help residents get up in the morning and staff checks on residents throughout the day. - RA voiced concerns regarding Resident #4's frequent falls. - Resident #4 falls a lot because the resident forgets to use the call bell to ask for help. - Resident #4's was able to use lift chair to stand up but still needed assistance to prevent falls. - Staff in the facility had received a memo communication from the Health and Wellness Director sometime after Thanksgiving instructing staff to keep the resident's lift chair unplugged unless staff was in the room providing care for the resident. - She refused to unplug Resident's #4 lift chair because he would not be able to get up. - RA reported that she did not see any other staff member unplug the resident's lift chair. - Lift chair was removed on 12/10/15 and resident has a recliner. - Resident #4 is unable to get out of recliner without assistance. Interview with a medication aide on 12/14/15 at 2:20 p.m. revealed: - When he had the lift chair, the resident could	D 482		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 482	Continued From page 140 get up independently. - Staff was told by the HWD to unplug the lift chair. - She refused to unplug it and some other staff refused as well because it is a restraint. - The resident has a new recliner now but he can't get up from the recliner either. - It takes 2 staff to get the resident up because "it restrains him". Confidential staff interview revealed: - Resident #4 had multiple falls and now the facility was "trapping him in his chair." - The HWD put a memo in the communication book dated 11/27/15 for all staff to read instructing staff to unplug Resident #4's lift chair when staff was not in his room with him. - "It's against the law... Most people refused to sign it." - Resident #4 was "Not happy ..."They took away his freedom. He can 't get up at all now. " - The staff person had not signed the memo written by the HWD or unplugged Resident #4's lift chair while the staff person was on duty. Confidential interview with a second staff person revealed: - Resident #4 had a history of frequent falls. - Resident #4 can transfer and walk with his walker with +2 assist. - Resident #4 likes to walk around inside the facility to "get his exercise." - Resident #4 used a lift chair to help him stand (with assistance). - The staff person observed Resident #4's lift chair unplugged "at least twice" so the staff person asked a Resident Aide (RA) why it was unplugged. - The RA told the staff person that the HWD had written a memo instructing staff to unplug the	D 482		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
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D 482	Continued From page 141 lift chair. - The staff person read the memo written by the HWD;" I did not agree with it because I felt like it was a restraint." - Resident #4 could not get up/out of the lift chair when it was unplugged. - The staff person did not unplug Resident #4's lift chair and did not sign the memo. - Resident #4 told the staff person he did not want his lift chair unplugged. - The staff person reported the concerns to the HWD and was told the chair was being unplugged to prevent Resident #4 from falling. Interview with Health and Wellness Director (HWD) on 12/15/15 at 12:15 p.m. revealed: - Resident #4 had a history of frequent falls. - The resident has had therapy after therapy for his falls. - He has decreased safety awareness. - There was a problem with the resident using his lift chair because Resident #4 would elevate the lift chair too high and topple over the resident would just slide out his lift chair. - He was not using the lift chair properly and could not demonstrate how to safely use to the HWD. - He would lean over and fall while reaching for things. - She was concerned with the resident's safety using his lift chair. - The HWD discussed with Resident #4's family and decided to unplug the resident's lift chair unless the resident was receiving the assistance of staff. HWD unsure of the date of this discussion. - She thought if the chair was unplugged the staff could be there to supervise the resident during transfers and ambulation. - The resident did not like it when the chair was	D 482		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE NEW BERN		STREET ADDRESS, CITY, STATE, ZIP CODE 1336 SOUTH GLENBURNIE ROAD NEW BERN, NC 28562		
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D 482	Continued From page 142 unplugged; he was so mad. - The goal was to get him to use his call bell. - She did not discuss with the PCP or ED prior to instructing staff to unplug the lift chair. - She did not think of it as a restraint but as a safety measure. - She contacted the family back and discussed getting a different chair. - He is not physically able to get out of the new recliner independently. - The resident is currently getting physical therapy. Review of Resident #4's record revealed: - No documentation of any falls caused by the use of the lift chair. - HWD documented in the resident's notes on 11/24/15 to start leaving Resident #4's lift chair unplugged unless staff is providing assistance. -HWD documented in the resident's notes on 11/30/15 that the HWD discussed with family member about Resident #4's lift chair contributing to his frequent falls and the HWD suggested to family to keep lift chair unplugged unless staff was with Resident #4. Interview with the ED on 12/15/15 at 2:10 p.m. revealed: - She found out about the lift chair being unplugged last Tuesday (12/08/15) or Wednesday (12/09/15) and she stopped it. - The resident got a new recliner on 12/10/15 for comfort. Interview with Resident #4's primary physician's assistant (PA) on 12/15/15 at 1:17 p.m. revealed: - PA has seen the resident only once on 12/04/15. - PA was aware of resident's history of frequent falls but was unsure of the number of falls the resident had in the last 2 months.	D 482		

Division of Health Service Regulation

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D 482	Continued From page 143 - PA stated the resident's lift chair was plugged in during her medical visit to the facility on 12/04/15. - During her visit at the facility on 12/04/15, Resident #4 independently used lift chair to assist him to stand. Resident used his walker to ambulate independently to bathroom and resident was able to come out of the bathroom without assistance and stepped up on the PA's scales to be weighed. - She did not believe that Resident #4's use of lift chair contributed to his frequent falls. - No one from the facility contacted her prior to unplugging the resident 's lift chair nor discussed any other needed fall precautions. Interview with the Physical Therapist on 12/11/15 at 9:30am revealed: - Resident #4 had multiple falls. - Resident #4 had "cognitive issues" and "pride" which contributed to his frequent falls. - Resident #4 had a lift chair. - The physical Therapist noticed documentation in Resident #4's chart "last week" that the lift chair was supposed to remain unplugged because of his history of falls. - "This is a restraint because he cannot get up at all now." - The Physical Therapist had discussed the lift chair with a facility Medication Aide (MA) and was told the MA thought unplugging the chair was a restraint but the HWD "made his wife sign a statement to remove the lift chair and use the regular recliner." - Resident #4 was unhappy about his chair being unplugged. - Resident #4's wife had contacted the Physical Therapist the previous week and was "very upset" and "crying" about the situation. - The Physical Therapist had not observed the facility implement any alternative interventions to	D 482		

Division of Health Service Regulation

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D 482	Continued From page 144 unplugging the lift chair. - The facility had not discussed alternative interventions with her. Interview with Resident #4's family member on 12/15/15 at 2:25 p.m. revealed: - She was concerned with resident's balance and feels like if he doesn ' t have someone to help him get up then he falls. - Resident #4 was able to use the lift chair independently to stand. - The HWD talked with the family member last week and the HWD voiced concerned for Resident #4 ' s safety using his lift chair. HWD stated Resident #4 was unsafe using lift chair and was dumped out of the chair if the resident raised the chair up too early or if the resident started to get up too early with the lift chair and lost his balance. - HWD had prior discussion with resident and HWD had unplugged the lift chair in Resident #4's room. - She was not notified or consulted about the lift chair being unplugged. - She was told by the HWD that the use of lift chair was causing a safety issue and the chair needed to be changed for the resident's safety. - She did not feel like she had a choice in removing the lift chair and replacing it with the recliner based on the HWD's concerns. - The resident cannot get to a standing position with the new recliner. - The resident cannot get out the recliner without assistance. Interview with Resident #4 on 12/15/15 at 2:25p.m. with family revealed: - Resident stated that unplugging the lift chair killed the power so he was not able to get up from the lift chair.	D 482		

Division of Health Service Regulation

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D 482	Continued From page 145 - Resident is unable to get up from recliner without assistance. Interview with the Executive Director (ED) on 12/11/15 at 4:00 p.m. revealed: - The facility's policy was to be a restraint free facility. - She told the HWD that unplugging Resident #4's lift chair would cause the lift chair to be a restraint. - The HWD told the ED that it was not a restraint. Interview with the Executive Director (ED) on 12/14/15 at 4:33 p.m. revealed: - She recently overheard staff members (could not recall date or which staff members) discussing Resident #4's lift chair. - Staff was talking about the lift chair being unplugged. - Staff reported the resident was getting mad when it was unplugged. - Staff reported the Health and Wellness Director (HWD) told them to unplug the chair because the resident was having so many falls. - ED told the HWD they could not unplug the chair because it would be a restraint. - HWD talked with the resident's family member and a new recliner was purchased. - The lift chair was removed and replaced with the recliner on 12/10/15. - The resident was able to use the lift chair to stand up. - The resident was not asking for assistance and he would lose his balance and fall when trying to walk independently. Interview with the Executive Director (ED) on 12/14/15 at 10:40 a.m. revealed: - Resident #4 was currently using the new	D 482		

Division of Health Service Regulation

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D 482	Continued From page 146 recliner in his room. - He was not using the reclining function of the recliner. - He has a stool under his legs. - He can get his legs off the stool independently. - She thinks the resident can get up from the recliner independently but she was not sure. - Physical therapy and occupational therapy are working with the resident with the recliner function.	D 482		
{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 observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to management and health care. The findings are: 1. Based on observations, interviews and record reviews, the administrator failed to assure the total operation of the facility to meet and maintain rules related to resident assessments, personal care and supervision, health care, medication administration, licensed health professional support and physical restraints. [Refer to Tag D980 G.S. 131D-25 Implementation (Type A2	{D912}		

Division of Health Service Regulation

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{D912}	Continued From page 147 Violation).] 2. Based on observations, record reviews, and interviews, the facility failed to assure referral and follow up to meet the routine and acute health care needs of 4 of 5 residents sampled (#1, #2, #3, #4) related to a failure to seek medical evaluation for a resident taking Coumadin after a fall with a reported head injury, failure to notify the physician of side effects of pain medication, refusal of CPAP and complaints of dizziness for one resident (#1); weight gain for one resident (#2); complaints of pain after a fall resulting in injury and requiring sutures and failure to coordinate transportation for physician appointments for one resident (#3); and, failure to notify the physician a gel seat cushion was not obtained for a resident with sacral decubitus and to coordinate podiatry care for on resident (#4). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type B Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to assure physician orders were implemented for 3 of 5 residents sampled (#1, #3, #4) for daily weights for one resident (#4); dressing changes for two residents (#3, #4); for CPAP, incentive spirometry and monitoring of bowel movements for one resident (#1). [Refer to Tag D276 10A NCAC 13F .0902(c) (3-4) Health Care (Type B Violation).]	{D912}		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

Division of Health Service Regulation

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D914	Continued From page 148 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect as evidenced by the failure to provide supervision in regards to falls. The findings are: Based on observations, record reviews and interviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 3 of 5 residents (#1, #3, #4) sampled with multiple falls, including falls resulting in head injuries, sutures, pneumothorax, broken rib, bruising, and skin tears. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).]	D914			
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the administrator failed to assure the total operation of the facility to meet and maintain rules related to resident assessments, personal care and supervision, health care, medication administration, licensed health professional support and physical restraints. The findings	D980			

Division of Health Service Regulation

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D980	Continued From page 149 are: Interview with the Executive Director (ED) on 12/14/15 at 10:40 a.m. revealed: - She was not a licensed Administrator. - She was currently working on obtaining her Administrator's license and expected to complete that process around February 2016. - The current licensed Administrator for the facility had been the Administrator since March 2015 but the Administrator was not usually at the facility. - The ED usually communicated with the Administrator daily via phone or email. - The ED usually discussed and updated the Administrator on what was going on with staff and residents during their communications. Noncompliance identified during the survey included: 1. Based on observations, record reviews and interviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 3 of 5 residents (#1, #3, #4) sampled with multiple falls, including falls resulting in head injuries, sutures, pneumothorax, broken rib, bruising, and skin tears. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] 2. Based on observations, record reviews, and interviews, the facility failed to assure referral and follow up to meet the routine and acute health care needs of 4 of 5 residents sampled (#1, #2, #3, #4) related to a failure to seek medical evaluation for a resident taking Coumadin after a fall with a reported head injury, failure to notify the physician of side effects of pain medication,	D980		

Division of Health Service Regulation

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D980	Continued From page 150 refusal of CPAP and complaints of dizziness for one resident (#1); weight gain for one resident (#2); complaints of pain after a fall resulting in injury and requiring sutures and failure to coordinate transportation for physician appointments for one resident (#3); and, failure to notify the physician a gel seat cushion was not obtained for a resident with sacral decubitus and to coordinate podiatry care for on resident (#4). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type B Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to assure physician orders were implemented for 3 of 5 residents sampled (#1, #3, #4) for daily weights for one resident (#4); dressing changes for two residents (#3, #4); for CPAP, incentive spirometry and monitoring of bowel movements for one resident (#1). [Refer to Tag D276 10A NCAC 13F .0902(c) (3-4) Health Care (Type B Violation).] 4. Based on observations, interviews, and record reviews, the facility failed to assure a physical assessment and evaluation was completed for Licensed Health Professional Support (LHPS) review for 3 of 5 residents sampled (#1, #4, and #5) with required tasks including one resident with a CPAP (#1); two residents receiving physical therapy, assistance with ambulation using a walker and/or wheelchair and assistance with transfers (#4, #5); one resident with orders for oxygen and nebulizer (#5); and, one resident with dressing changes for a sacral decubitus (#4). [Refer to Tag D280 10A NCAC 13F .0903 (c) (1-4) (Licensed Health Professional Support).] 5. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed	D980		

Division of Health Service Regulation

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D980	Continued From page 151 prescribing practitioner and in accordance with the facility's policies and procedures for 4 of 13 residents (#2, #6, #7, #8) observed during the medication passes, including errors with insulin, oral diabetes medication, inhaler for breathing problems, and a medication used to treat and prevent stomach ulcers and 1 of 6 residents (#8) sampled for record review related to errors with sliding scale insulin. [Refer to Tag D358 10A NCAC 13F .1004 (a) Medication Administration.] 6. Based on observation, interview and record review, the facility failed to assure physical restraints, including an unplugged lift chair and recliner, were used only after an assessment and care planning process had been completed and used only after alternatives had been tried and a physician's order obtained for 1 of 1 residents (#4) sampled with restraints. [Refer to Tag D482 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives.] 7. Based on observations, interviews, and record reviews, the facility failed to assure an assessment was completed within 10 days following a change of condition for 2 of 2 residents sampled (#1, #3) with significant changes in their ability to walk or transfer. [Refer to Tag D255 10A NCAC 13F .0801 (c) Resident Assessments] _____ The facility was requested to submit a plan of protection on 01/11/2016. CORRECTION DATE FOR THE TYPE A2	D980		

Division of Health Service Regulation

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D980	Continued From page 152 VIOLATION SHALL NOT EXCEED JANUARY 14, 2016.	D980			