Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041030	A. BUILDING: _____ B. WING _____	01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT	201 WEST HARTLEY DRIVE HIGH POINT, NC 27265

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D 000	Initial Comments The Adult Care Licensure Section conduted an annual survey on 01/27/16, 01/28/16, and 01/29/16.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 2 of 3 sampled non-clinical staff (Staff C and D) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G.S. 131E-256. The findings are: 1. Review of Staff C's personnel record revealed: - Staff C was hired as a housekeeper on 10/28/13. - Her job responsibilities included providing cleaning services throughout the facility and residents' rooms. - There was no documentation of a HCPR check. Refer to interview on 01/29/16 at 1:00 pm with the Business Office Coordinator (BOC). Refer to interview on 01/29/16 at 1:05 pm with the	D 137		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Executive Director (X6) DATE 2/26/16

Approved with addendum (pg41)
3/9/16 BMoore

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D 137	Continued From page 1 Health and Wellness Director. Refer to interview on 01/29/16 at 2:15 pm with the Resident Care Coordinator. Refer to interview on 01/29/16 at 2:30 pm with the Executive Director. 2. Review of Staff D's personnel record revealed: - Staff D was hired on 03/17/14 and worked as a housekeeper. - Her duties included providing cleaning services throughout the facility and in residents' rooms. - There was no documentation of a HCPR check. Refer to interview on 01/29/16 at 1:00 pm with the Business Office Coordinator (BOC). Refer to interview on 01/29/16 at 1:05 pm with the Health and Wellness Director. Refer to interview on 01/29/16 at 2:15 pm with the Resident Care Coordinator. Refer to interview on 01/29/16 at 2:30 pm with the Executive Director. Interview on 01/29/16 at 1:00 pm with the Business Office Coordinator (BOC) revealed: - It was her responsibility to run the HCPR checks on new employees. - She did not realize that HCPR checks were required for every employee. - She thought that HCPR checks were only required for staff who provided direct care to the residents, such as personal care aides and medication aides. - She thought the state and federal criminal background checks performed on every new employee upon hire was sufficient.	D 137		

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D 137	Continued From page 2 - There was no documentation of a HCPR check for either Staff C or Staff D. Interview on 01/29/16 at 1:05 pm with the Health and Wellness Director revealed: - The BOC was responsible for performing the HCPR checks on new employees. - She was not aware the HCPR had to be performed on each employee. Interview on 01/29/16 at 2:15 pm with the Resident Care Coordinator revealed: - The BOC was responsible for performing the HCPR checks on new employees. Interview on 01/29/16 at 2:30 pm with the Executive Director revealed: - The BOC was responsible for completing required information in employee files. - She was not aware the HCPR check was required on every employee, she thought it was required for care staff only. _____ The facility provided a Plan of Protection on 01/29/16 as follows: - An immediate audit of employee files will be conducted by the Business Office Coordinator (BOC). - Any missing Health Care Personnel Registries (HCPR) will be performed and placed in current employee files. - A tracking system will be developed for required information in employee files, to include HCPR by the BOC. - The Executive Director will monitor the tracking system weekly for the next 4 weeks, and then on a monthly basis, thereafter. CORRECTION DATE FOR THE TYPE B	D 137		

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D 137	Continued From page 3 VIOLATION SHALL NOT EXCEED MARCH 14, 2016.	D 137		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record review, the facility failed to ensure referral and follow up to meet the routine and acute health care needs of 2 of 5 sampled residents (Residents #1 and #5) with orders for neurology and neurosurgery follow-up appointments following acute and chronic brain hemorrhaging and application of compression stockings. The findings are: A. Review of Resident #1's current FL-2 dated 09/02/15 revealed: -Diagnoses included chronic diastolic heart failure, focal seizure disorder, and epilepsy. -A physician's order to check the blood pressure (BP) daily. -No ordered BP parameters for notifying the physician. Review of the September 2015 Vital Signs log revealed the BP ranged from 128/90 to 156/92. (National Institutes of Health [NIH] defines normal blood pressure for adults as a systolic pressure	D 273		

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D 273	Continued From page 4 below 120 and a diastolic pressure below 80.) Review of the October 2015 Vital Signs log and staff notes revealed BP ranged from 112/72 to 210/115. Review of October 2015 staff notes for Resident #1 revealed the resident was sent to the local Emergency Room (ER) three times in October for high BP and complaints of headache. Review of hospital ER records for Resident #1 revealed: -Resident #1 was evaluated and treated in the ER three times in October 2015. -On 10/17/15, the resident arrived at 11:18 am with complaints of "severe" headache and hypertension. BPs were 220/120, 194/114, 200/82, 181/87, 187/81, and 174/83. Head CT showed no acute hemorrhage. Hospital staff administered antihypertensives, narcotics, and antinausea medications intravenously and the resident returned to the facility on 10/17/15 at 3:43 pm with a final BP of 152/82. -On 10/19/15, the resident arrived at 12:26 am with complaints of headache and hypertension and a BP of 225/99. Hospital staff administered medications intravenously and the resident returned to the facility on 10/19/15 at 3:00 am with a final BP of 175/95. -On 10/20/15, the resident arrived at 7:17 am with complaints of left arm weakness, trouble gripping, headache, nausea, and dizziness. BPs were 176/91 and 166/85. Head CT showed no acute hemorrhage. Hospital staff administered medications intravenously and the resident returned to the facility on 10/20/15 at 11:03 am with a final BP of 147/69. Review of the November 2015 Vital Signs log	D 273		

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D 273	Continued From page 5 from 11/01/15 through 11/13/15 revealed the BP ranged from 102/68 to 140/84. Review of staff notes for Resident #1 revealed on 11/14/15 (time illegible), the resident's BP was 200/148 and the resident was sent to the local ER. Review of hospital records for Resident #1 dated 11/14/15 through 11/17/15 revealed: -The resident arrived at the ER on 11/14/15 at 11:46 pm for evaluation of headache and hypertension. -BPs were 245/108, 216/110, 225/107, 178/101, and 135/47. -Head CT showed an acute left-sided hemorrhage. In addition, two "large" remote (old) right-sided infarcts (localized areas of dead tissue resulting from failure of blood supply), "small to medium" left-sided infarct demonstrating chronic hemorrhage, and numerous microbleeds throughout the brain. -The resident was admitted to the hospital. Review of the hospital discharge summary dated 11/17/15 revealed: -The resident was admitted for hypertensive emergency with BP 210/110 in the ER with seizures. -The resident was seen by Neurology in the hospital. -The physician recommended "more better control" of the resident's blood pressures. -Two new antihypertensive medications were added to the resident's current medication regime. -The resident was to follow up with (named Neurosurgeon) in 2 weeks and (named Neurologist) in 4 weeks. -"Appointments have been put in the system and	D 273		

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D 273	Continued From page 6 will be made here by the nurse". Review of Resident #1's record revealed: -A copy of the 11/17/15 hospital discharge summary was in the resident's record. -The new medications had been started as ordered. -There was no documentation the resident followed up with the Neurosurgeon or Neurologist as ordered in the discharge summary. -There was no documentation of daily BP checks after 11/29/15. -A staff note dated 01/20/16 documented the resident's return to the facility from the hospital with a BP of 202/100. There was no documentation to indicate when the resident was transferred to the hospital or the reason for the transfer. -There was no documentation the attending physician was notified of the 01/20/16 ER visit or BP upon return to the facility. Review of hospital ER records for Resident #1 dated 01/20/16 revealed: -Resident #1 arrived at the ER on 01/20/16 at 5:04 am with complaints of headache and hypertension. -BPs were 179/101 and 191/108. -Head CT showed complete resolution of November 2015 hemorrhaging and no acute findings. -Hospital staff administered an oral antihypertensive medication and the resident was discharged back to the facility with a discharge BP of 202/100. Interview on 01/28/16 at 12:40 pm with a Medication Aide (MA) revealed: -She transcribed the 11/17/15 hospital discharge orders.	D 273		

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D 273	Continued From page 7 -She only looked at the medication list and did not read the discharge summary. -She did not see the orders for the Neurology and Neurosurgery appointments. -If she had seen the orders, she would have made a copy and given them to the transportation person to schedule. Interview on 01/28/16 at 12:05 pm with the Health and Wellness Director (HWD) revealed: -It was the responsibility of the MA on duty to make a copy of incoming orders for follow up appointments and give to the transportation aide to schedule. -She "usually" reviewed all resident discharge summaries, but did not recall seeing the orders for the follow up appointments for Resident #1. Interviews on 01/28/16 at 10:34 am and 01/28/16 at 4:30 pm with two family members for Resident #1 revealed: -Neither of the family members were aware of the hospital discharge orders for the resident to follow up with the Neurologist and the Neurosurgeon. -The facility was responsible for making appointments and transporting the resident to all doctor's appointments. Interview on 01/28/16 at 2:45 pm with Resident #1's attending physician revealed: -The Nurse Practitioner (NP) routinely made rounds at the facility and managed care for the facility residents. -He "certainly" would have expected the facility to schedule the follow up appointments with Neurology and Neurosurgery. Interview on 01/28/16 at 3:45 pm with the NP revealed: -She saw the resident on 11/18/15 following her	D 273		

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D 273	Continued From page 8 hospitalization, but did not see the hospital discharge summary or the orders for the follow up visits. -It was possible the discharge summary had not yet been filed in the resident's record. -She was not aware the resident was transported to the ER on 01/20/16, or that she returned to the facility with a BP of 202/100. -The NP routinely saw residents in the facility to follow up after a visit to the hospital. -The NP saw residents at the facility the day prior, on 01/27/16, but did not see Resident #1 because she had not been informed the resident had been transferred to the ER on 01/20/16. Interview on 01/29/16 at 12:14 pm with a second MA revealed: -She was the night shift MA on duty in the early morning hours of 01/20/16. -Between 3:00 am and 4:00 am, she heard a "banging" on the wall in Resident #1's room. -When the MA investigated, the resident was walking out of the bathroom and told the MA she had a seizure. -The resident was trembling, complaining of headache, and was unsteady on her feet. -Staff called 911 and the MA sat with the resident until EMS arrived. -The MA did not notify the attending physician of the resident's seizure or subsequent transfer to the hospital. -The MA was nervous and forgot to notify the physician because this was the first time she had ever had to send a resident out to the hospital. Interview on 01/29/16 at 9:50 am with a third MA revealed: -She was the day shift MA on duty on the morning of 01/20/16 when the resident returned with a BP of 202/100.	D 273		

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D 273	Continued From page 9 -She assumed the night shift MA notified the physician when the resident was transported out to the ER that morning. -The NP was in the facility that day seeing residents and the MA assumed she (the MA) reported the resident's BP to the NP, but did not specifically recall whether she did or not. Interview on 01/28/16 at 11:17 am with Resident #1 revealed: -The facility staff had "just came" and checked her blood pressure and said it was okay. -She routinely saw "the nurse" at the facility and did not go out for any other doctor appointments. -She was not aware of any follow up appointments ordered on 11/17/15. B. Review of Resident #5's current FL2 dated 03/25/15 revealed: -Diagnoses included congestive heart failure, sleep apnea, hypertension, hyperlipidemia, chronic obstructive pulmonary disease (COPD), oxygen dependent, depression, and anxiety. -An order for TED (Compression stockings) hose apply in the AM off in PM as needed for edema. Review of the Resident Register revealed the resident was admitted to the facility on 03/21/13. Review of Resident #5's record revealed: -A clarification to the Nurse Practitioner (NP) dated 09/08/15, staff wrote "order for TED hose on in the am, off in the pm PRN edema was removed from the list from the hospital. Resident wants this order added back." -The NP wrote "TED hose on in the AM off in the PM." Observation on 01/27/16 at 10:48 am of Resident #5 revealed:	D 273		

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D 273	Continued From page 10 -The resident was sitting in a reclining chair. -Both the resident's feet were placed on the floor and covered with a blanket. -The resident pulled the blanket back and showed her feet. -The resident was not wearing TED hose. -Both feet had mild edema on the tops of her feet, with the left foot observed to have more moderate edema, than the right foot. Second observation on 01/28/16 at 8:00 to 12:00 pm of Resident #5 revealed: -The resident was sitting in a reclining chair. -The reclining chair lifted the resident's feet off the floor. -The resident did not have TED hose on. -A pair of black TED hose were observed on a table near the chair where the resident was sitting. -The resident's feet were puffy the same as yesterday (1/27/16), with the left foot appeared to have more puffiness than the right foot. Review of Resident #5's Personal Service Plan dated 04/05/15 revealed: -The resident was not reluctant to care, and did not require additional staff involvement because of verbal or physical reluctance to accept care. -No documentation of the TED hose listed on the service plan. -The resident needed limited assistance with dressing and grooming. -The resident required assistance putting on/taking off socks and hose, but did not specify if the assistance needed was limited or full assistance. Review of Resident #5's Medication Administration Records (MARs) for October 2015 revealed:	D 273		

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D 273	Continued From page 11 -The computer generated MARs listed TED hose apply in the morning at 8:00 am and remove in the evening at 8:00 pm. -Staff documented applying and removing Resident #5's TED hose for 31 days from October 1-31, 2015. Review of Resident #5's November 2015 MARs revealed: -The computer generated MAR listed TED hose apply as directed every morning and remove at bedtime. -Staff documented on the MAR applying and removing Resident #5's TED hose for four days November 1-4, 2015. -On November 5, 2015 staff circled initials as not applied with the reason documented the resident was in the hospital. -There was no documentation on the MAR from November 5-30, 2015 for the applying and removing TED hose. Further review of Resident #5's record revealed: -Handwritten MARs for November 7-30, 2015. -TED hose was not documented on the MAR. Review of Resident #5's printed December 2015 and January 2016 MAR revealed: -TED hose was not documented on the MAR. Review of the Licensed Health Professional Support (LHPS) evaluation completed for Resident #5 dated on 10/08/15 revealed: -The task for applying and removing TED hose. -"TED hose were on but were tight, creased and causing pain." -The resident had 3-4 + edema. -Facility staff were in-serviced on measuring and monitoring TED hose. Review of the most current LHPS evaluation	D 273		

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D 273	Continued From page 12 completed for Resident #5 dated on 12/28/15 revealed: -The task of applying and removing TED hose. -The resident had new TED hose that fit properly. -The resident had 2-3 + edema to lower extremities. Interview on 01/28/16 at 11:55 am with Resident #5 revealed: -She had a pair of black TED hose. -She wore the TED hose because she had swelling in her feet and legs. -She had not worn her TED hose since Monday, (01/25/16) because staff did not come into her room to assist with the TED hose. -She often forgot to ask staff to assist her with putting the TED hose on. -It would help if facility staff followed-up with her to assist with putting the TED hose on. Interview on 01/28/16 at 12:17 pm with a first shift Medication Aide (MA) revealed: -She worked yesterday (1/27/16) and today. -She "forgot to put Resident #5's TED hose yesterday (1/27/16) and this morning." -Today, she remembered after 12:00 pm today and put the TED hose on Resident #5. -She documented applying Resident #5's TED hose on the MAR. -The MA said she documented, the MA looked at the MARs and said "I thought the TED hose was on the MAR, I know they (TED hose) were on the MAR last month." -She remembered Resident #5's TED hose without looking at the MARs because the resident had TED hose for long time. -Sometimes the resident told staff she did not want the TED hose on right now because she did not feel like getting up. -The resident did not tell staff when she was	D 273		

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D 273	Continued From page 13 ready to get-up or remind staff to put the TED hose on. -Staff on the second shift were responsible for removing Resident #5's TED hose. Interview on 01/28/16 at 2:59 pm with a second shift MA revealed: -Staff did not assist Resident #5 with putting on TED hose because if staff assistance was needed it would be on the MARs. -Sometimes Resident #5 asked facility staff to assist with TED hose, but she only assisted if the resident asked. -Staff were able to view Resident #5's Service Plan to determine care needs of the resident, but if it's not on the MARs then it's not considered an order for staff to follow. Interview on 01/28/19 at 11:43 am with the Health and Wellness Director and the Resident Care Coordinator revealed: -They thought Resident #5's TED hose were ordered as needed. -They were unaware the order on 09/08/15 from the Nurse Practitioner (NP) changed TED hose to applying in AM and removing in PM daily. -The person receiving the order for Resident #5's TED hose should have clarified the order with the resident's physician, to determine she wanted the TED hose as needed or daily. Interview on 01/28/16 at 3:40 pm with the therapist providing physical therapy to Resident #5 revealed: -She assisted Resident #5 with physical therapy twice weekly. -Resident #5 often did not wear her TED hose. -Resident #5 told staff to come back later because she did not feel like getting dressed.. -She was unaware if facility staff followed-up with	D 273		

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BROOKDALE HIGH POINT	201 WEST HARTLEY DRIVE HIGH POINT, NC 27265

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D 273	Continued From page 14 the resident later to see if she was ready to have TED hose applied. -She noticed Resident #5 sat in the reclining chair a lot, and the resident's feet would hang down causing them to swell. -The resident had a history of congestive heart failure and swelling in her legs and feet was a concern. -When she was with the resident she reminded her to recline her chair and lift her feet off the floor. Interview on 01/28/16 at 4:10 pm with the NP revealed: -Facility staff had verbally told her that Resident #5 was "non-compliant" with putting on her TED hose on herself. -She was unaware if facility staff offered to assist Resident #5 with putting on her TED hose. -No one informed her that staff at the facility had offered to put the TED hose on and the resident refused. Interview on 01/29/16 at 2:15 pm with Resident #5's family member revealed: -Resident #5's TED hose hurt and the resident did not want to put them on. -Resident #5 had congestive heart failure, COPD and other health concerns. -Even if the TED hose were the right size Resident #5 needed staff assistance to put the TED hose on and take them off. -She had talked to the Business Office Coordinator "until she was red in the face," regarding facility staff not assisting Resident #5 with putting on and taking off TED hose. On 01/28/16, the Executive Director submitted a Plan of Protection as follows: -An audit would be completed beginning	D 273		

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D 273	Continued From page 15 immediately of all resident records to identify any issues requiring referral or follow up. -Follow up of any identified issues would be completed immediately. -Appropriate associates would be re-educated prior to their next schedule shift regarding appropriate follow up. -Going forward, the HWD or Resident Care Coordinator (RCC) will review all orders and discharge summaries to assure appropriate follow up. CORRECTION DATE FOR THE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 28, 2016.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure documentation of implementation of physician's orders for 1 of 5 sampled residents (Resident #5) related to applying and removing TED (Compression stockings) hose and CPAP (Continuous Positive Air Pressure). The findings are:	D 276		

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D 276	Continued From page 16 Review of Resident #5's current FL2 dated 03/25/15 revealed: -Diagnoses included congestive heart failure, sleep apnea, hypertension, hyperlipidemia, chronic obstructive pulmonary disease (COPD), oxygen dependent, depression, and anxiety. -An order for TED hose apply in the AM off in PM as needed for edema. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 03/21/13. 1. Review of Resident #5's record revealed: -A clarification to the Nurse Practitioner (NP) dated 09/08/15, staff wrote "order for TED hose on in the am, off in the pm PRN edema was removed from the list from the hospital. Resident wants this order added back." -The NP wrote "TED hose on in the AM off in the PM." Observation on 01/27/16 at 10:48 am of Resident #5 revealed: -The resident was sitting in a reclining chair. -Both of the resident's feet were placed on the floor and covered with a blanket. -The resident pulled the blanket back and showed her feet. -The resident was not wearing TED hose. -Both feet had mild edema on the tops of both feet, with the left foot having more moderate edema, than the right foot. Second observation on 01/28/16 at 8:00 to 12:00 pm of Resident #5 revealed: -The resident was sitting in a reclining chair. -The reclining chair lifted the resident's feet off the floor.	D 276		

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D 276	Continued From page 17 -The resident did not have TED hose on. -A pair of black TED hose were observed on table near the chair were the resident was sitting. -The resident's feet were puffy the same as yesterday (1/27/16), with the left foot appeared to have more puffiness than the right foot. Review of Resident #5's Personal Service Plan dated 04/05/15 revealed: -The resident not reluctant to care, and did not require additional staff involvement because of verbal or physical reluctance to accept care. -No documentation of the TED hose. -The resident needed limited assistance with dressing and grooming. -The resident required assistance putting on/taking off socks and hose. -The type of assistance needed (limited or extensive) was not listed on the Service Plan. Review of Resident #5's Medication Administration Records (MARs) for October 2015 revealed: -The computer generated MARs listed TED hose to be applied in the morning at 8:00 am and removed in the evening at 8:00 pm. -Staff documented applying and removing Resident #5's TED hose for 31 days from October 1-31, 2015. Review of Resident #5's November 2015 MARs revealed: -The computer generated MAR listed TED hose apply as directed every morning and remove at bedtime. -Staff documented on the MAR applying and removing Resident #5's TED hose for four days in November 1-4, 2015. -On November 5, 2015 staff circled initials and documented the reason on the back of MAR	D 276		

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D 276	Continued From page 18 "resident was in the hospital." -There was no documentation on the MAR TED hose was applied from November 5-30, 2015 on the computer generated MAR. Further review of Resident #5's record revealed handwritten MARs for November 7-30, 2015. -TED hose was not documented on the MAR. Review of Resident #5's printed December 2015 and January 2016 MAR revealed TED hose was not documented on the MAR. Review of the Licensed Health Professional Support (LHPS) evaluation completed for Resident #5 dated 10/08/15 revealed: -The task of applying and removing TED hose. -TED hose were on but were tight, creased and causing pain. -The resident had 3-4 + edema. -Facility staff was in-serviced on measuring and monitoring TED hose. Review of the LHPS evaluation completed for Resident #5 dated on 12/28/15 revealed: -The RN documented the task of applying and removing TED hose. -The resident had new TED hose that fit properly. -The resident had 2-3 + edema to lower extremities. Interview on 01/28/16 at 11:55 am with Resident #5 revealed: -She had a pair of black TED hose. -She wore the TED hose because she had swelling in her feet and legs. -She had not worn her TED hose since Monday, (January 25, 2016) because staff did not come into her room to assist with applying the TED hose.	D 276		

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D 276	Continued From page 19 -She often forgot ask staff to assist her with putting the TED hose on, and staff did not offer to help with the TED hose. Interview on 01/28/16 at 12:17 pm with a first shift Medication Aide (MA) revealed: -First shift MAs were responsible for applying TED hose. -She yesterday and today and forgot to put Resident #5's TED hose yesterday (1/27/16) and this morning. -She remembered after 12:00 pm today and put the TED hose on Resident #5. -She documented applying Resident #5's TED hose on the MAR. -The MA then, looked at the MARs and said "I thought the TED hose was on the MAR, I know they (TED hose) were on the MAR last month." -She remembered Resident #5's TED hose without looking at the MARs because the resident had an order for TED hose for long time. -Sometimes the resident would say she did not want the TED hose on right now because she did not feel like getting up. -She did not remember to go back and check, the resident should let staff know when she was ready to get dressed. -Staff on the second shift were responsible for removing Resident #5's TED hose. Interview on 01/28/16 at 12:48 pm with the contract pharmacist revealed: -She did not have an order for TED hose for Resident #5. -If pharmacy received an order TED hose it would be printed on the MAR. -The facility staff should send the order for TED hose to the pharmacy. -According to their computer, they had never received an order for Resident #5's TED hose.	D 276		

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D 276	Continued From page 20 Interview on 01/28/16 at 2:50 pm with a second shift Medication Aides (MA) revealed: -He did not assist Resident #5 with TED hose because the resident's TED hose were not documented on the MARs. -If TED hose were not documented on the MAR that meant the resident performed the task herself. -If the resident wanted staff assistance she could ask for help, but staff did not go to the room and ask the resident if she needed help with the TED hose. -About one month ago Resident #5's family member came to him "complaining" that facility did not help the resident with putting on and taking off TED hose. He told the family member the same thing, that staff did not assist because the TED hose were not documented on the MARs. Interview on 01/28/16 at 2:59 pm with a 2nd, second shift MA revealed: -She sometimes worked the first and second shift as a MA. -She was unaware that Resident #5 had an order for staff implement applying and removing TED hose. -The MA receiving the order should have documented TED hose on the MARs. -First shift started at 6:00 am, so it was the first shift MA's responsibility to assist residents with putting on TED hose in the morning. -Staff did not assist Resident #5 with applying and removing TED hose because TED hose were not documented on the MARs. -Sometimes Resident #5 asked facility staff to assist with TED hose, but she only assisted if the resident asked.	D 276		

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D 276	Continued From page 21 Interview on 01/28/19 at 11:43 am with the Health and Wellness Director and the Resident Care Coordinator revealed: -They thought Resident #5's TED hose was ordered as needed. -They were unaware the order on 09/08/15 from the NP changed the TED hose to applying in AM and removing in PM daily. Interview on 01/28/16 at 3:40 pm with the therapist providing physical therapy to Resident #5 revealed: -She assisted Resident #5 with physical therapy twice weekly. -She said Resident #5 was often "non-compliant" with wearing TED hose because when staff came to the room to apply TED hose Resident #5 would tell staff to come back letter, because she did not feel like getting dressed right then. -She had observed this on a couple occasions. -She knew the NP was aware that sometimes Resident #5 told staff she did not want to put the TED hose on. -She was unaware it was facility staff responsibility to ensure implementation of Resident #5's TED hose. -She noticed Resident #5 sat in the reclining chair a lot, and the resident's feet would hang down causing them to swell. -The resident did have a history of congestive heart failure and swelling in her legs and feet was a concern. Interview on 01/28/16 at 4:10 pm with the Nurse Practitioner (NP) revealed: -Facility staff had verbally told her that Resident #5 was "non-compliant" with putting on her TED hose. -She had observed a couple of occasions when the resident did not put her TED hose on.	D 276		

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D 276	Continued From page 22 -She was unaware if facility staff offered to assist Resident #5 with putting on her TED hose. -No staff at the facility had informed they offered to apply the TED hose and the resident refused. -She was unaware if it was facility staff responsibility to implement applying and removing Resident #5's TED hose. Interview on 01/29/16 at 2:15 pm with Resident #5's family member revealed: -Resident #5's TED hose hurt and the resident did not want to put them on. -Resident #5 had congestive heart failure, COPD and other health concerns. -Even if the TED hose were the right size Resident #5 needed staff assistance to put the TED hose on and take them off. -She had expressed to the Business Office Coordinator that facility staff did not assist Resident #5 with putting on and taking off TED hose. -Previously, when facility staff assisted Resident #5 with applying and removing TED hose, they would come and ask if the resident wanted the TED hose on. If the resident said come back because she was not ready to get dressed, or was in the bathroom, facility staff would not come, and then say the resident refused to wear the TED hose 2. Review of Resident #5's current FL2 dated 03/25/15 revealed diagnoses included sleep apnea. -An order for "CPAP (Continuous Positive Air Pressure) on QHS (at bedtime) off Q am (each morning)." Observation on 01/27/16 at 10:48 am revealed: -A CPAP machine sitting on the floor beside the resident's recliner.	D 276		

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D 276	Continued From page 23 -There was a mask to cover the nose/mouth and straps that go around the resident's head to hold the mask in place. -The hose leading from the mask to the machine was intact and appeared to be in good repair. Interview on 01/27/16 at 10:50 am with Resident #5 revealed: -She needed another mask because the mask did not fit properly. -A family member purchased the mask about 1 month ago because the previous mask was cracked and rubbed sores on her face. -Facility staff did not assist her with putting the mask on, she put it on herself. -Because the mask was uncomfortable some nights she did not put the mask on. -Some nights she fell asleep and forgot to put the mask on. -It would be nice if facility staff would come to her room and ask if they could put the mask on for her. Review of Resident #5's Personal Service Plan dated 04/05/15 revealed: -Resident #5's chronic condition was COPD. -The resident not reluctant to care, and did not require additional staff involvement because of verbal or physical reluctance to accept care. -The resident had respiratory equipment and used a CPAP at bedtime. -Staff was to provide help with putting water in the machine. -Staff assistance with putting the CPAP on or taking it off was not documented. Review of nurses' notes for Resident #5 revealed: -On 07/01/15 (no time documented) resident is saying she forgets to put the mask (CPAP) on and falls asleep in the chair. She is checked on	D 276		

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D 276	Continued From page 24 every two hours. -On 08/30/15 at 12:00 pm staff documented Resident #5's CPAP was broken, and the resident's insurance would not pay for another machine (family and physician made aware). -The resident's family request facility staff to check on the resident every 30 minutes. Review of Resident #5's Medication Administration Record (MAR) for October 2015 revealed: -The computer generated MAR listed CPAP as off in the morning at 8:00 am and on in the evening at 11:00 pm. -Staff documented the application and removal of CPAP on at 11:00 pm and off at 8:00 am from for 31 days from October 1-31, 2015. Review of Resident #5's November 2015 MAR revealed: -The computer generated MARs listed CPAP off in the morning at 8:00 am, and on in the evening at 8:00 pm. -Staff documented on the MAR the application and removal of CPAP for four days from November 1-4, 2015. -On November 5, 2015 staff circled initials and documented on back of the MAR the resident went to the hospital. -There was no documentation on the computer generated MAR from November 5-30, 2015. Further review of Resident #5's record revealed handwritten MAR for November 7-30, 2015. -CPAP was not documented on the MAR. Review of Resident #5's printed December 2015 and January 2016 MARs revealed CPAP was not documented on the MARs.	D 276		

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D 276	Continued From page 25 Review of the LHPS evaluation completed for Resident #5 dated 10/08/15 revealed: -The task of monitoring CPAP. -There was no other documentation. Review of the most current LHPS evaluation completed for Resident #5 dated 12/28/15 revealed: -The RN documented the task of monitoring CPAP. -There was no other documentation. Interview on 01/28/16 at 12:17 pm with a first shift Medication Aide (MA) revealed: -The first shift started at 6:00 am. -She did not assist Resident #5 with taking off her CPAP. -She was unaware if Resident #5 put the CPAP on at night. -Resident #5's CPAP used to be on the MARs requiring staff to assist with implementing the CPAP before bed and removing in the morning. -Now the CPAP was not on the MARs, so was not sure if second shift staff assisted the resident. -She was unaware why the CPAP dropped of the MAR. Interview on 01/28/16 at 2:51 pm with a second shift Medication Aide (MA) revealed: -He did not assist Resident #5 with implementing her CPAP before bed. -The CPAP was not printed on the MARs so he was not responsible for assisting the resident with implementing the CPAP. -The resident was usually up late and when he left at 10:00 pm he verbally reminded the resident to put her CPAP on, when she got sleepy. -About a month ago the resident's family member "complained" to him that staff did not help the resident with implementing the CPAP and he told	D 276		

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D 276	Continued From page 26 the family member the same, it was not on the MARs and the resident was responsible for implementing without staff assistance. -He previously left a note for third shift staff to remind Resident #5 to put her CPAP on. Interview on 01/28/16 at 4:10 pm with the Nurse Practitioner (NP) revealed: -Facility staff had verbally told her that Resident #5 was "non-compliant" with wearing her CPAP (unable to recall a specific date). -The resident did not put the CPAP on before going to sleep. -She was unaware if facility offered to assist the resident with putting the CPAP on. -Resident #5 was able to put the CPAP on, but needed staff assistance to ensure it was applied correctly or to remind the resident to put the CPAP on. -No staff at the facility had informed her they offered to assist the resident with putting the CPAP on and the resident refused. -She was unaware facility staff was responsible to implement putting on and taking off Resident #5's CPAP. Interview on 01/29/16 at 3:09 pm with Resident #5's family member revealed: -A couple months ago she purchased Resident #5 a new mask. -The previous mask was cracked and scratched up the resident's face. -She asked facility staff why they did not assist Resident #5 with implementing the CPAP before going to sleep. -She was told by staff that it was not their responsibility, but Resident #5 had to put the CPAP on and take it off herself.	D 276		

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D 310	Continued From page 27	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure thickened liquids for 1 of 1 sampled residents (#3) was prepared and served as ordered by the physician. The findings are: Review of Resident #3's current FL2 dated 02/08/15 revealed: -No diagnoses were documented on the FL2. - There was no diet order on the current FL2. Review of Resident #3's previous FL2 dated 01/19/15 revealed diagnoses of dementia, chronic obstructive pulmonary disease (COPD), depression, and osteoporosis. -There was no documented diet order on the FL2. Review of Resident #3's record revealed: -An undated "Addendum to the FL-2" signed by the physician with orders for nectar thick liquids and chopped meats. Review of physician's order sheet signed by the Nurse Practitioner on 01/27/16 revealed orders for mechanical chopped meats, and "thickened liquids."	D 310		

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D 310	Continued From page 28 Review of Resident #3's Personal Service Care Plan dated 08/31/15 revealed: -Resident #3 needed assistance in the dining room while eating (no documentation of the assistance needed). -The resident had consistency modified diet (no consistency documented). -Resident should be served finger foods. -The physician believe the resident needed help in the dining rooms during meals (no documentation why). -Staff was to provide attention and physical assistance in the dining room (no documentation of the assistance needed). Review of Resident #3's speech therapy progress notes revealed: -10/21/14 the resident had a dysphagia evaluation. -The resident exhibited mild to moderate oropharyngeal dysphagia, requiring nectar thickened liquids. Observation on 01/27/16 at 12:32 pm of the kitchen revealed 24 each, 4 ounce cups of nectar pre-thickened liquids. -No more pre-thickened liquids were observed in the facility. -A container of powdered thickener was on the countertop in the kitchen. -The container had less than 2 tablespoons of thickener. Review of the diet list posted in the kitchen revealed: -Resident #3 was on thickened liquids (no consistency documented) and chopped meats. Interview on 01/27/16 at 12:25 pm with the Food Service Manager revealed:	D 310		

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D 310	Continued From page 29 -The diet list was prepared by staff in the "office." -Resident #3 was on thickened liquids, but she was unaware of the consistency ordered. -There was no consistency listed on the diet list. -Kitchen staff did not have anything to do with thickening Resident #3's beverages, that was done by the Resident Associates. Interview on 01/27/16 at 12:35 pm with a first shift, Resident Associate (RA) revealed: -Resident #3 was ordered thickened liquids. -Resident #3 was the only resident in the facility on thickened liquids. -She was unsure of the consistency, it was listed on the cups of water (pre-thickened liquids). -Resident Associates (RAs) thickened Resident #3's beverages. -She had not received training how to thickened Resident #3's beverages, but was verbally told by another RA how to thickened liquids. -She did not serve Resident #3's beverages today and was unaware of the beverage inside the cup sitting in front of Resident #3. Observation on 01/27/16 from 12:37 pm to 1:00 pm revealed: -Resident #3 was sitting in her wheelchair at the dining room table. -There was a 20 ounce black metal cup. -The beverage inside the cup was not viewable due to the metal and color. -At 12:40 pm the RA gave the resident a 4x3 inch square of Jell-O. -The resident ate 100% of the Jell-O, without difficulty. Interview on 01/27/16 at 12:43 pm with a second, 1st shift RA revealed: -Resident #3 had thickened tea in the black cup that was on the table in front of the resident.	D 310		

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D 310	Continued From page 30 -She gave the resident tea earlier today, around 10:00 am. -She put 1 tablespoon and 1 teaspoon of thickener in Residents #3's 20 ounces of tea. -She was unaware of the consistency of thickener ordered Resident #3, she followed instructions on the back of the container for thickening liquids. -The facility had pre-thickened water only. -She had not received training on how to prepare thickened liquids. -She followed the instructions on the back of the container or thickener. Review of the instructions on the container of thickener revealed: -To obtain nectar consistency in 4 ounces of beverages use 3½ to 4 teaspoons of thickener. Interview on 01/27/16 at 12:46 pm with Resident #3 revealed: -She was always given Jell-O to eat. -She had a red beverage inside her cup. -The red beverage was not thickened. -When asked, where she got the red beverage, the resident did not respond. Second interview on 01/27/16 at 12:48 am with the second, 1st shift RA revealed: -She was unaware how Resident #3 got the red beverage. -Resident #3 had tremors that caused her to shake, and it was impossible for the resident to open the cup herself. -Third interview on 01/27/16 at 12:55 pm with the second, 1st shift RA revealed: -The RA asked Resident #3 if she could see what was in her cup. -The beverage inside the cup was dark colored soda.	D 310		

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D 310	Continued From page 31 -She had not received training how to thickened liquids. -She was verbally told by another staff person the resident was ordered thickened liquids, but the staff did not tell her the consistency. -She "saw nectar consistency" on the pre-thickened liquids and thought that was the consistency ordered for Resident #3. -Prior to meals being served residents had options of picking from two appetizer. -The appetizers today were garden salad and Jell-O -Resident #3 always picked the Jell-O as her appetizer. -Resident #3 told her the Jell-O was softer than the garden salad and "easier to go down." Interview on 01/27/16 at 12:56 pm with the Business Office Coordinator: She worked some Sundays and observed Resident #3's family member bringing beverages to the resident. -She told the family member that Resident #3 could not have the soda. -She did not go back to check to see if the resident kept the sodas. -The facility had not provided in-service or informed staff what to do about thickening the beverages in Resident #3's room. -The facility had not provided staff training, that she could recall, how to prepare thickened liquids. Interview on 01/27/16 at 12:55 pm with the Health and Wellness Director (HWD) revealed: -Resident #3 was non-compliant with thickened liquids in the past, consuming beverages without thickener. -She was unaware the resident was still non-compliant with consuming beverages that	D 310		

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D 310	Continued From page 32 were not thickened. -Resident #3 had not been provided with thickener in her room because the resident was physically unable to maneuver putting thickener in her beverages. -Resident #3 was unable to open her cup, beverages containers due to the resident's shaking. Second interview on 01/27/16 at 1:01 pm with the HWD revealed: -She was aware that Resident #3's family was non-compliant with thickening beverages bought to the resident's room. -The family member did not ask staff for thickener for the resident's beverages. -She had not notified the physician regarding Resident #3 being non-compliant with thickening her own beverages. -She was aware Resident #3 was ordered thickened liquids for swallowing difficulties, but did not know the specific reason or the why the resident needed thickened liquids. -She did not know the consistency of thickened liquids ordered. Observation on 01/27/16 at 12:50 pm of Resident #3's room revealed: -5 each 12 ounce cans of dark colored soda. Interview on 01/28/16 at 11:25 am with Resident #3 revealed: -She was in the hospital and after discharge, she was ordered thickened liquids. -Her liquids should be thickened, but she was unaware of the consistency. -A previous "food manager" told her liquids needed to be thickened, but did not tell her what consistency. -Until this conversation she was unaware	D 310		

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D 310	Continued From page 33 thickened liquids had a consistency. -The "food manager" made sure she had thickened liquids and even gave her thickened liquids to take to the room. -The "food manager" no longer worked at the facility, and now no one assisted her with thickened liquids. -Some days she got liquids with meals thickened, some days she did not. -She had beverages in her room, given by her family member. -Facility staff were aware of the beverages and did not provide thickener for the beverages. -She had not asked facility staff for thickener to thickened beverages. Interview on 01/28/16 at 3:20 pm with the Speech Therapist revealed: -Resident #3 was in speech therapy due to dysphagia treatment with hopes of decreasing risk of aspiration. -Resident 3's primary care physician ordered speech therapy back in 2014. -The resident "had improved, but she doubted improvements were enough for the resident to go without thickener in her beverages." -She had consulted many times with facility staff about the proper way to thicken Resident #3's beverages. -She had sample little packets of thickener in Resident #3's room to ensure the resident had thickener for beverages in her. -The thickener she gave the resident were free samples, she thought facility staff provided the resident with thickener. -She "had problems with facility staff putting ice in the pre-thickened liquids." -She "had conversations with facility staff to not give Resident #3 Jell-O and ice cream" because they "break-down," but facility staff continues to	D 310		

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D 310	Continued From page 34 give the resident ice cream and Jell-O.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure orders for readmission to the facility were complete for 1 of 5 sampled residents (Resident #1) regarding blood pressure monitoring following hositalization. The findings are: Review of Resident #1's current FL-2 dated 09/02/15 revealed: -Diagnoses included chronic diastolic heart failure, focal seizure disorder, and epilepsy. -A physician's order to check the blood pressure (BP) daily. -No ordered BP parameters for notifying the physician.	D 344		

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D 344	Continued From page 35 Review of October 2015 staff notes for Resident #1 revealed the resident was sent to the local Emergency Room (ER) three times in October for high BP and complaints of headache. Review of hospital ER records for Resident #1 revealed: -Resident #1 was evaluated and treated in the ER three times in October 2015. -On 10/17/15, the resident arrived at 11:18 am with complaints of "severe" headache and hypertension. BPs were 220/120, 194/114, 200/82, 181/87, 187/81, and 174/83. Head CT showed no acute hemorrhage. Hospital staff administered antihypertensives, narcotics, and antinausea medications intravenously and the resident returned to the facility on 10/17/15 at 3:43 pm with a final BP of 152/82. -On 10/19/15, the resident arrived at 12:26 am with complaints of headache and hypertension and a BP of 225/99. Hospital staff administered medications intravenously and the resident returned to the facility on 10/19/15 at 3:00 am with a final BP of 175/95. -On 10/20/15, the resident arrived at 7:17 am with complaints of left arm weakness, trouble gripping, headache, nausea, and dizziness. BPs were 176/91 and 166/85. Head CT showed no acute hemorrhage. Hospital staff administered medications intravenously and the resident returned to the facility on 10/20/15 at 11:03 am with a final BP of 147/69. Review of the November 2015 Vital Signs log from 11/01/15 through 11/13/15 revealed the BP was obtained daily as ordered and ranged from 102/68 to 140/84. Review of staff notes for Resident #1 revealed on 11/14/15 (time illegible), the resident's BP was	D 344		

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D 344	Continued From page 36 200/148 and the resident was sent to the local ER. Review of hospital records for Resident #1 dated 11/14/15 through 11/17/15 revealed: -The resident arrived at the ER on 11/14/15 at 11:46 pm for evaluation of headache and hypertension. -BPs were 245/108, 216/110, 225/107, 178/101, and 135/47. -Head CT showed an acute left-sided hemorrhage. In addition, two "large" remote (old) right-sided infarcts (localized areas of dead tissue resulting from failure of blood supply), "small to medium" left-sided infarct demonstrating chronic hemorrhage, and numerous microbleeds throughout the brain. -The resident was admitted to the hospital. Review of the hospital discharge summary dated 11/17/15 revealed: -The resident was admitted for hypertensive emergency with BP 210/110 in the ER with seizures. -The physician recommended "more better control" of the resident's blood pressures. -Two new antihypertensive medications were added to the resident's current medication regime. -Discharge orders did not address how often to check the resident's BPs. Review of the resident's November 2015 Vital Signs log from 11/17/15 through 11/30/15 revealed: -Staff obtained the resident's BP daily as previously ordered except for on 11/17/15, 11/20/15, 11/23/15, and 11/30/15 when the BP was not documented as checked. -The BP ranged from 126/80 to 147/90.	D 344		

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D 344	Continued From page 37 Review of Resident #1's record revealed: -There was no documentation staff notified the physician of daily BPs not being included on the hosital discharge summary. -Daily BP checks were not continued after the 11/29/15 reading of 136/97. -A BP of 138/85 was documented for December 2015 (no date). -A BP of 121/82 was documented for January 2016 (no date). -A staff note dated 01/20/16 documented the resident's return to the facility from the hospital with a BP of 202/100. -There was no documentation to indicate when the resident was transferred to the hospital or the reason for the transfer. Interview on 01/28/16 at 12:05 pm with the Health and Wellness Director (HWD) revealed: -When Resident #1 was discharged from the hospital on 11/17/15, the discharge summary did not include an order to resume the resident's daily BP checks, so the BP monitoring reverted to monthly, per the facility's standard for checking routine vital signs on all residents. -Staff should have notified the resident's Nurse Practitioner (NP) that the daily BP checks were not reordered and clarified the order with the NP. Interview on 01/28/16 at 12:40 pm with a Medication Aide (MA) revealed: -She transcribed the 11/17/15 hospital discharge orders. -She did not continue the daily BP monitoring because the hospital physician did not write specific BP monitoring orders. -She did not contact the attending physician or the NP for clarification. -Usually, if they (the physician) wanted the BP	D 344		

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D 344	Continued From page 38 checked more often, they would order it. Interview on 01/28/16 at 2:45 pm with Resident #1's attending physician revealed: -The NP routinely made rounds at the facility and managed care for the facility residents. -It was not unusual for "those kinds of orders" to not get carried over when residents were discharged from the hospital and staff should call the physician's office to get them "put back on". Interview on 01/28/16 at 3:45 pm with the NP revealed: -She saw the resident on 11/18/15 following her hospitalization, but did not see the hospital discharge summary or recall reading the CT scan reports describing the resident's hemorrhages. -It was possible the discharge information had not yet been filed in the resident's record. -She was not aware staff discontinued the resident's daily BP checks. -She received a fax from the facility today, 01/28/16, notifying her that the daily BPs had been stopped after the resident's hospitalization in November, and she responded with an order to discontinue the daily BP checks because she thought the resident's BPs had been stable. -She was not aware of the resident's latest transport to the hospital on 01/20/16, or that she returned to the facility with a BP of 202/100. -"In light of this information", it was her intent to have her office contact the facility to reinstate the daily BP checks.	D 344		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are	D912		

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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
D912	Continued From page 39 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding health care referral and follow up and other staff qualifications. The findings are: A. Based on observations, interviews, and record review, the facility failed to ensure referral and follow up to meet the routine and acute health care needs of 2 of 5 sampled residents (Residents #1 and #5) with orders for neurology and neurosurgery follow-up appointments following acute and chronic brain hemorrhaging and application of compression stockings. [Refer to Tag 273, 10A NCAC 13F .0902(b) Type A2 Violation)]. B. Based on observations, interviews and record reviews, the facility failed to ensure 2 of 3 sampled non-clinical staff (Staff C and D) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G.S. 131E-256. [Refer to Tag 137, 10A NCAC 13F .0407(a)(5) (Type B Violation)].	D912		

The following is a summary of the Plan of Correction for Brookdale High Point. This Plan of Correction is in regards to the Corrective Action Report dated February 12, 2016. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

10ANCAC 13F.0407(a)(5) NC Health Care Registry (Type B)
(a) Each staff person at an adult care home shall:
(5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;

- An audit was completed on associate files on 1/29/16 by Business Office Coordinator.
- Identified employees missing documentation of North Carolina Personal Registry review were checked in the Health Care Registry with documentation placed in their file on 1/29/16.
- A tracking system was completed for tracking compliance by the Business Office Coordinator/Executive Director/Designee on 2/1/16.
- Going forward, this tracking system will be reviewed for completion for new associates by the Business Office Coordinator/Executive Director/Designee at least on a weekly basis for the next 4 weeks.
- Thereafter the tracking system will be checked at least monthly by the Executive Director/Designee for compliance.

10A NCAC 13F .0902 Health Care (Type A2)
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of resident's records

- An audit of current resident charts was completed on 2/8/16 to determine the need for any outstanding healthcare referral or follow up.
- Any identified needs were completed/clarified at that time.
- The New Order Tracking Form will be utilized by associates for new/changed orders to include those residents that have been in the hospital.
- The New Order Tracking Forms will be reviewed by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee daily when in the community for the next 30 days for completion of orders and appropriate follow through to include those resident orders for anyone that had been at the hospital.
- Thereafter, the "New Order Tracking Forms" will be reviewed randomly, but at least on a weekly basis by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee to maintain appropriate follow-up is being completed by staff.
- Appropriate associates were reeducated regarding the use of the New Order Track Form and Notebook for follow-up appointments by the Health and Wellness Director on 2/9/16.

Per telephone conversation with Kim Stoneking on 3/9/16 at 3:56 pm, the completion date for 10A NCAC 13F.0902(b) Healthcare A2 Violation is 2/28/16. The completion date for all other Violations and/or citations is 3/4/16. —
PMoore

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.

- The New Order Tracking Form will be utilized by associates for new/changed orders to include those residents that have been in the hospital.
- The New Order Tracking Forms will be reviewed by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee daily when in the community for the next 30 days for completion of orders and appropriate follow through to include those resident orders for anyone that had been at the hospital.
- Thereafter, the "New Order Tracking Forms" will be reviewed randomly, but at least on a weekly basis by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee to maintain appropriate follow-up is being completed by staff.
- Appropriate associates will be reeducated regarding the use of the New Order Track Form and Notebook for follow-up appointments by the Health and Wellness Director on 3/2/16.

10A NCAC 13F .0904 Nutrition and Food Service

(e) Therapeutic Diets in Family Care Homes:

4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

- Therapeutic diets will be followed as ordered by the physician.
- Community associates will be retrained regarding what type of therapeutic diets are currently in the community; to include training on thickened liquids, no later than 3/2/16.
- The Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee will complete daily observations, when present in the community, for 3 weeks, and then random observations, for compliance thereafter.

10A NCAC 13F .1002 Medication Orders

(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:

(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;

(2) if orders are not clear or complete; or

(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.

The facility shall ensure that this verification or clarification is documented in the resident's record.

- The "New Order Tracking Form" will be utilized by associates for new/changed orders to include orders for residents that return from the hospital.
- Verification/clarification on any unclear, incomplete, or previous orders that were not carried over will be requested from the prescribing/primary physician.
- "New Order Tracking Forms" will be reviewed by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee daily for 4 weeks, when present in the community, for completion of orders and appropriate follow through for unclear, incomplete, or previous orders that were not carried over.
- Thereafter orders will be reviewed randomly, but at least on a weekly basis by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee when in the community.
- There will be documentation at the next MT/SIC meeting where the "New Order Tracking Form" will be reviewed as well as appropriate follow through of orders that are unclear, incomplete, or previous orders that were not carried over. This training will occur no later than 3/2/16.

G.S. 131D-21 (2) Declaration of Residents' Rights
Each facility shall treat its residents in accordance with the provisions of this Article. Each resident shall have the following rights:
(2) To receive care and services which are adequate and appropriate and in compliance with relevant federal and state laws and rules and regulations.

- Associates will be retrained on the community's policy regarding Resident Rights in regards to receiving appropriate referral and follow up care and services by 3/2/16.