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
	HAL029001	A. BUILDING: _____ B. WING _____	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE RETIREMENT CENTER	2968 OLD SALISBURY ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 11/16/16 and 11/17/16.	D 000		
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 reviews, the facility failed to send a resident to the hospital in a timely manner for medical treatment for 1 of 7 sampled residents (Resident # 6) who was experiencing respiratory difficulty. The findings are: Review of Resident #6's current FL2 dated 03/01/16 revealed diagnoses included Alzheimer's dementia and hypertension. Interviews on 11/16/16 at 9:50 am and 11/17/16 at 11:22 am and 1:25 pm with Resident #6's Power of Attorney (POA), who was also her roommate, revealed: -Resident #6 had just returned from the Emergency Room (ER) 11/16/18 around 4 am due to difficulty breathing. -On the morning of 11/15/16, the POA notified the day shift Medication Aide (MA) of the resident's difficulty breathing, congestion, and cough and had repeatedly requested the resident be sent out	D 273	The following POC should not be considered an admission by Brookstone Retirement Center, LLC, that the findings are appropriate or accurate. Facility will continue to offer education and training concerning referral and follow-up and reinterate Brookstone Retirement Center's policy of "When in doubt, send them out" and also if there is a question about a referral or follow-up issue, a member of the management team will be consulted. As we did with all supervisory staff/medication aide staff upon exit of survey team,per plan of protection, we will make sure any new staff are aware of Brookstone Retirement Center's policy on sending residents out of the facility for medical care or for follow-up. This policy will be included in all new hire training as well as orientation. RCCs will continue to monitor for compliance and make Administrative Assistants, DON or Administrator aware if compliance to policy is not being followed. Plan of protection was implemented upon exit of the survey team and corrections were made at that time concerning making staff aware of Brookstone Retirement Center's referral & follow-up policy. Date of completion: 11/17/16 - 12/05/16	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: DON — (X6) DATE: 12/22/16

STATE FORM 5899 U93P11 If continuation sheet 1 of 7

Reviewed and accepted.
1/23/17

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cough" and that the MA on duty refused to send the resident out to the hospital.
-The family member called the MA and told her to send Resident #6 out to the hospital for evaluation, but the MA said the resident had COPD and it was a "declining process and it won't get better".
-The MA told the family member she assessed the resident and "didn't see the need" to send her out.
-The MA also stated she needed to get permission from the RCC before the resident could be sent out to the hospital and that she could only go to the nearest hospital.
-The family member told the MA to send the resident "wherever".
-The family member called the MA again later that day and told her he would take the resident himself, but he had no license and no ride and she needed to send the resident out "now".
-The MA told the family member she had performed another assessment on Resident #6 and "there was no need" to send her out.
-The POA called the family member on the night of 11/15/16 and informed him that the evening shift MA sent Resident #6 out to the hospital for evaluation at 11:00 pm.

Review of Resident #6's ER notes dated 11/15/16 revealed:
-Resident #6 arrived to the ER at 11:32 pm via ambulance for evaluation of shortness of breath.
-The resident had been given oxygen during transport to the hospital and her oxygen saturation upon arrival was 100% on 2 liters of oxygen, respiratory rate was 28, and temperature was 99.7 degrees Fahrenheit.
-Respiratory assessment by hospital staff revealed shortness of breath, wheezing and rhonchi (caused by obstruction or secretions in

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the larger airways), as well as cough and fever.
-Hospital staff administered a breathing treatment, a pain reliever/fever reducer, an antibiotic, and a corticosteroid.
-Vital signs taken on 11/16/16 at 1:52 am were temperature of 100.4 degrees Fahrenheit, respiratory rate 22, and oxygen saturation 92% on room air.
-The resident was discharged from the ER with a diagnosis of "COPD with acute exacerbation" and prescriptions for an antibiotic and a steroid for continued treatment.

Interview on 11/16/17 at 4:37 pm with the day shift MA revealed:
-Resident #6's POA "complained" about Resident #6 having breathing difficulty about 9:30 am after the 8:00 am scheduled breathing treatment.
-The POA preferred (named) hospital, but it was okay for her to go "wherever", and he stated, "I'm going to get her help regardless".
-She told the POA that she "didn't see the need" to send the resident out because the resident had COPD and it was a "declining process" and nothing helps.
-The POA requested Resident #6 be sent out 3 more times that day, and the MA assessed the resident after each request but did not see the need for her to be sent out.
-If the resident needed to be sent to the hospital for evaluation, she would have to get permission from the RCC to send her out.
-She reported off to the oncoming shift MA, but did not inform the oncoming shift of Resident #6's complaints and did not document in the staff notes because "there was nothing to write about".
-She did not discuss Resident #6's difficulty breathing with the RCC.

Interview on 11/17/16 at 12:00 pm with the

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evening shift MA revealed:
-On 11/15/16, Resident #6's POA asked her to send Resident #6 to (named) hospital because the resident's cough and shortness of breath was getting worse.
-Resident #6 "didn't look like she felt good", and was coughing up mucus and had already received her 9 pm breathing treatment, so she decided to send Resident #6 to the hospital.
-The POA did not object to sending Resident #6 to the closest hospital.

Interviews on 11/17/16 at 2:08 pm and 4:17 pm with the RCC revealed:
-She received a text message from the evening shift MA that Resident #6 was coughing and congested and the MA was sending her out to the hospital for evaluation.
-The facility's "motto" was "when in doubt, send out" and there was no need to get permission to send a resident out.
-She worked as the MA on the night of 11/14/16, and Resident #6 had some congestion and a cough during her shift.
-On the morning of 11/15/16, she notified the day shift MA about Resident #6's cough and congestion and instructed the day shift MA to contact the physician and notify him of the resident's condition.
-She was not aware the day shift MA had not notified the physician, nor responded to the POA's multiple requests to send Resident #6 to the hospital for evaluation.

Interview on 11/17/16 at 2:44 pm with the Director of Nursing (DON) revealed:
-If a resident requested to be sent to the hospital, they were suppose to be sent out.
-"Our motto is, when in doubt, send out".
-The evening shift MA called him on 11/16/16

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D 273	Continued From page 5 around 5:00 am and told him Resident #6 was returning from the hospital after being sent out at 11:00 pm the night before. -There was no facility policy requiring MAs to get permission from anyone prior to sending a resident to the hospital if they needed or requested to go. -MAs were not qualified to perform assessments on residents or determine whether or not a resident needed to be sent out for evaluation. -It was the expectation of the DON that MAs send a resident to the hospital if they were requesting to go, or call the physician or the DON for instructions if they were not sure what to do. -He was available to staff 24/7 for any questions or concerns that might arise during their shift. On 11/17/16, the facility submitted a Plan of Protection as follows: -The facility will begin an immediate audit to identify any health care issues requiring referral or follow up. -All Medication Aides will be inserviced regarding timely and appropriate referral and follow up prior to their next scheduled shift. -The DON and the Resident Care Coordinator will monitor to ensure on going compliance. CORRECTION DATE FOR THE A2 VIOLATION SHALL NOT EXCEED DECEMBER 17, 2016.	D 273		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 6 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 healthcare referral and followup. The findings are: Based on observations, interviews and record reviews, the facility failed to send a resident to the hospital in a timely manner for medical treatment for 1 of 7 sampled residents (Resident # 6) who was experiencing respiratory difficulty. [Refer to Tag 273, 10A NCAC 13F .0902 (b) (Type A2 violation).]	D912		

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to the hospital for evaluation, but the MA would not send the resident out.
-The day shift MA told the POA that she "didn't see the need" to send the resident out because the resident had COPD (Chronic Obstructive Pulmonary Disease) and it was a "declining process and won't get better".
-The POA told the MA the resident was "gasping for breath and it is worse than the COPD", but the MA stated it was "just COPD and it will be okay".
-The MA stated she would need to get permission from the Resident Care Coordinator (RCC) to send Resident #6 to the hospital and that the resident would have to go to the nearest hospital, not the POA's hospital of choice.
-The POA told the MA he preferred (named) hospital, but it was okay for her to go "wherever".
-The POA called a family member around 10:00 am on 11/15/16 and reported Resident #6's condition and that the MA on duty would not send the resident to the hospital.
-The POA asked the family member to call the facility and tell them to send Resident #6 to the hospital.
-The family member called him back and told him he spoke with the MA and the MA told him that Resident #6 was fine and she "did not see the need" to send the resident to the hospital.
-The evening shift MA came on duty at 7:00 pm and after Resident #6 did not improve after her scheduled 9:00 pm breathing treatment, the evening shift MA sent the resident to the hospital around 11:00 pm.

Telephone interview on 11/17/16 at 9:47 am with Resident #6's family member revealed:
-He received a call from Resident #6's POA around 10:00 am on the morning of 11/15/16 stating that the resident was "having difficulty breathing and was very congested with a bad