STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064008	A. BUILDING: _____ B. WING _____	R 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ROCKY MOUNT	650 GOLDROCK ROAD ROCKY MOUNT, NC 27804

(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 and the Nash County Department of Social Services conducted an annual and follow-up survey on August 15, 2017 through August 16, 2017.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure that 1 of 5 sampled residents (Resident #3) requiring supervision were being supervised according to their care plan and needs and resulting in 7 falls in 4 months. The findings are: Review of Resident #3's current FL-2 dated 04/26/17 revealed: -Diagnoses included vitamin D Deficiency, memory loss, edema, hypothyroidism, depression, and gastro esophageal reflux disease. -The resident was semi-ambulatory. Review of FL-2 addendum dated 4-26-17 for Resident #3 revealed: -Additional diagnosis of edema to both feet,	D 270		

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decrease memory, behavior problems with dementia, inappropriate behaviors at times, recent falls.
-Resident #3 was using a walker for ambulation.
-Resident #3 would benefit from Physical therapy and Occupational therapy.

Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 05/01/17.

Review of Resident #3's care plan dated for 05/01/17 revealed:
-Resident #3 required extensive assistance to use the toilet, get dressed, ambulation, and grooming.
-Resident #1 required minimal assistance to transfer.

Review of an incident and accident report dated 05/03/17 revealed:
-Resident #3 had an unwitnessed fall in his room at 10:50 PM.
-There were no apparent injuries noted.
-Resident #3's family was notified on 05/03/17 by phone at 10:55 PM.
-The primary care physician was notified by fax on 05/03/17 at 11:00 PM.

Review of a faxed document to the physician dated 05/04/17 revealed
-The fax was addressed to Resident #3's physician regarding a fall on 05/03/17.
-There was no apparent injuries noted on the document.
-The doctor responded on 05/08/17, "thanks for the information".

Review of an incident and accident report dated 05/04/17 revealed:

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D 270	Continued From page 2 -Resident #3 had an unwitnessed fall in his room at 10:30 AM. -The resident hit his head and had an abrasion to his head. -Resident #3 was sent to the emergency room for further treatment. -Resident #3's family was notified on 05/04/17 by phone at 11:00 AM. -The primary care physician was notified by fax on 05/04/17 at 1:00 PM. Review of a faxed document to the physician dated 05/04/17 revealed -The fax was addressed to Resident #3's physician regarding a fall on 05/04/17. -Resident #3 was sent to the emergency room for evaluation. -The doctor responded on 05/08/17, "thanks for the information". Review of an incident and accident report dated 06/07/17 revealed: -Resident #3 had an unwitnessed fall in his room at 7:30 AM. -Resident #3 complained of right hip pain. -Resident #3 was sent to the emergency room for further treatment. -Resident #3's family was notified one 06/07/17 by phone at 8:30 AM. -The primary care physician was notified by fax on 06/07/17 at 2:00 PM. Review of a faxed document to the physician dated 06/08/17 revealed -The fax was addressed to Resident #3's physician regarding a fall on 06/08/17. -Resident #3 was sent to the emergency room for evaluation. -The doctor responded on 06/08/17, "thanks for	D 270		

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D 270	Continued From page 3 the information". Review of an incident and accident report dated 06/25/17 revealed: -Resident #3 had an unwitnessed fall in his room at 8:00 AM. -There were no apparent injuries noted. -Resident #3's family was notified on 06/25/17 by phone at 10:00 AM. -The primary care physician was notified by fax on 06/25/17 at 10:05 AM. Review of a faxed document to the physician dated 06/25/17 revealed -The fax was addressed to Resident #3's physician regarding a fall on 06/25/17. -There were no apparent injuries noted on the document. -The doctor responded on 06/26/17, "thanks for the information". Review of an incident and accident report dated 06/30/17 revealed: -Resident #3 had an unwitnessed fall in his room at 7:30 AM. -There were no apparent injuries noted. -Resident #3's family was notified on 06/30/17 by phone at 8:30 AM. -The primary care physician was notified by fax on 06/30/17 at 10:00 AM. Review of a faxed document to the physician dated 06/30/17 revealed -The fax was addressed to Resident #3's physician regarding a fall on 06/30/17. -There were no apparent injuries noted on the document. -The doctor responded on 06/30/17, "thanks for the information".	D 270		

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D 270	Continued From page 4 Review of an incident and accident report dated 07/09/17 revealed: -Resident #3 had an unwitnessed fall in his room at 8:00 AM. -Resident #3 sustained a skin tear to his right elbow. -First Aide was done for the resident and he was not sent out. -Resident #3's family was notified on 07/09/17 by phone at 8:00 AM. -The primary care physician was notified by fax on 07/09/17 at 11:00 AM. Review of a faxed document to the physician dated 07/09/17 revealed -The fax was addressed to Resident #3's physician regarding a fall on 07/09/17. -There were a superficial injury which was a skin tear to the right elbow. -The doctor responded on 07/11/17, "thanks for the information". Review of an incident and accident report dated 07/28/17 revealed: -Resident #3 had an unwitnessed fall in his room at 8:30 AM. -There were no apparent injuries noted. -Resident #3's family was notified on 07/28/17 by phone at 11:30 AM. -The primary care physician was notified by fax on 07/28/17 at 11:30 AM. Review of a faxed document to the physician dated 07/28/17 revealed -The fax was addressed to Resident #3's physician regarding a fall on 07/28/17. -There were no apparent injuries noted on the document. -The doctor responded on 07/28/17, "thanks for	D 270		

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D 270	Continued From page 5 the information". Review of the facility's falls policy revealed: -The staff are to provide first aide or call 911 and follow the directions of the 911 operator. -The staff should notify the Health and Wellness Director and the Executive Director. -The staff should notify the primary care physician for evaluation, care, and treatment as indicated. -The staff should notify the family or responsible party and document in the resident's record. -The staff should document any injuries, resident's response, and any interventions taken in the resident's record. -All falls should be discussed in the morning stand up meetings. -Additional interventions should be documented on the resident's service plan if recurrent falls occur. -The Health and Wellness director or Executive Director are responsible for making sure staff are completing this documentation and following this policy. Review of personal care log for Resident #3 revealed: -On 5-4-17 at 10:30 AM Resident #3 was trying to get into recliner chair and hit head on the wall. Resident #3 was sent to the emergency room (ER). -On 6-7-17 at 7:30 AM Resident #3 was transferring from wheelchair to recliner and loss balance resulting in a fall. Resident hit buttocks and complained of pain in upper right thigh. Resident #3 was unable to transfer and complained of increased leg pain at 11:30 AM Resident #3 was sent to the ER. Interview with a Personal Care Aide (PCA) on 08/16/17 at 10:30 AM revealed:	D 270		

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-If a resident falls and hit his head they would get the Mediation Aide, take vital signs, call family members, call 911, and fax the primary care physician.
-If the resident does not hit his head then they will take vital signs and do range of motion with them.
-Resident #3 has fallen a lot on first shift.
-She was not sure how many times but it was due to his wheelchair being in his way.
-The staff had been told to move the wheelchair so the resident would not try to ambulate by himself.
-Most of the falls happened due to the resident trying to ambulate without assistance.
-The staff had increased supervision with Resident #3 by checking on him every 2 hours.
-There was no documentation that supervision had been increased.
-The have started leaving Resident #3's door open so the staff can check on him when they walk by.
-Resident #3 could use his call bell and has used it in the past.
-Resident #3 did not like to use the call bell because he wants to be independent.

Interview with a second PCA on 08/16/17 at 10:39 AM revealed:
-The facility falls policy is for the staff to call the Medication Aide, stay with the resident, and do not move the resident.
-If Resident #3's wheelchair is left near him he will try to get in it without assistance and fall.
-As long as Resident #3 can't see the wheelchair he will not try to get in it.
-The staff check on Resident #3 every 2 hours.
-The staff also leave his door open so they can walk by and check on Resident #3 periodically throughout the day.
-There was no documentation that 2 hour checks

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were being done.
-Resident #3 had received physical therapy to assist him.

Interview with a Medication Aide on 08/16/17 at 7:47 AM revealed:
-The facility's policy for falls was to check the resident for injury, call 911 if there was any injury or they hit their head, notify the Health and Wellness Director, call family or responsible party, notify the primary care physician, get vitals, and fill out an incident report.
-Resident #3 had some falls due to him not using his call bell.
-Resident #3 would refuse assistance from staff because he wanted to be independent.
-The facility had increased his monitoring since the resident had multiple falls.
-The staff were checking on Resident #3 at least every 2 hours or more often if they could, but she was not sure how often.
-Resident #3 was getting Physical Therapy at one time but they had discharged him.
-Resident #3 was refusing therapy and was not progressing so they discharged him.
-Resident #3 did have a fall back in June of 2017 and had a hip injury.
-Resident #3 would be going to an orthopedics appointment today to follow up about that hip due to continued pain.
-There was no documentation that Resident #3 had increased supervision.

Interview with Resident #3's family member on 8/16/17 at 10:41 a.m. revealed:
-In fall on June 7, 2017, Resident #3 got a real bad contusion on the right hip.
-Resident #3 was sent to the emergency room and got x-rayed.
-Resident #3 has fallen several times since he

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moved into facility on May 1, 2017.
-One of the reasons Resident #3 was placed in a facility was because he was falling at home.
-Resident #3 says sometimes he forgot about the call light and what it was for.
-Staff was educated to make sure call light was in Resident #3's reach and remind him to use it.
-After Resident #3's fall on June 7, 2017, the staff was educated to remove his wheelchair from in front of him so that he would not try to reach for it.

Interview with Physical Therapy on 08/16/17 at 12:00 p.m. revealed:
-Resident #3 received physical therapy for about three to three and one half months.
-Resident #3 was referred to physical therapy for weakness.
-When Resident #3 was asked to do physical therapy exercises he was unable to do them.
-Resident #3 "plateaued" after he fell in June 2016 and had pain to the right hip.
-Resident #3 had falls because he failed to call for assistance due to his issues with memory.

Interview with the Health and Wellness Director on 08/16/17 at 7:53 AM revealed:
-When a falls occurs the staff should check the resident for any injuries, take vital signs, notify the family, notify the primary care physician, and notify the Health and Wellness Director.
-Resident #3 has had several falls since he was admitted.
-She was not sure exactly how many falls she would have to go back and review his chart.
-The staff had increased supervision by checking on Resident #3 every 2 hours.
-Normally the staff only checked on residents every 4-6 hours.
-The staff had left Resident #3's door open so that staff could walk by and check on him

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D 270	Continued From page 9	D 270		

periodically.
-There was no documentation of increased supervision.
-The staff had also gotten a Physical Therapy consult and encouraged Resident #3 to use his call bell when he needed help.
-No other interventions had been done for Resident #3.

Interview with the Executive Director on 08/16/17 at 10:55 AM revealed:
-Resident #3 has had anywhere from 6-7 falls since he was admitted to the facility.
-The staff should be rounding on Resident #3 every 2 hours.
-The staff had encouraged Resident #3 to use his call bell when he needed assistance.
-Resident #3 did received some Physical Therapy but he was not sure how long ago.
-The staff should assess the resident's when they have a fall.
-The staff should take the resident's vital signs and assess for any injuries.
-If there are no injuries then they should report to Health and Wellness Director, the resident's family, and the primary care physician.
-If there was an injury or the resident had hit their head then they should also include calling 911 and sending the resident to the emergency room for evaluation.
-The staff had discussed the falls for Resident #3 but they had not put anything new into place other than what they were already doing.

The facility failed to assure the needs and current symptoms were assessed and supervision was provided for Resident #3. The facility's failure to implement interventions for Resident #3 who had a history of memory loss and dementia, and who would forget to call for assistance, resulted in the

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D 270	Continued From page 10 resident suffering 7 unwitnessed falls in 4 months, including 2 falls with injury. This failure resulted in substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation. _____ Review of the facility's Plan of Protection dated 08/16/17 revealed: -The staff will initiate 30 minute checks immediately by assigning a PCA to that resident. -The Executive Director will meet with the family about getting a private companion to stay with Resident #3 during waking hours. -Resident #3 will follow up with Orthopedics and the facility will obtain further instructions from Orthopedics physician. -Any future residents identified with multiple falls will be re-assessed for proper placement. -The Executive Director and Health and Wellness Director will meet with family about proper placement. -Physical and Occupational therapy will be ordered as needed. -A PCA will be assigned to perform 30 minute checks and the checks will continue until a new plan of care can be developed for that resident. -The Executive Director will be responsible for making sure this is implemented and done by 08/16/17. -The staff will review incident reports and refer to primary physician and Physical Therapy for safety intervention at next collaborative Care Meeting on 08/17/17. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 15, 2017.	D 270		

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D 358	Continued From page 11	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 5 residents (#2) including Remeron, a medication used for depression. The findings are: Review of Residents #2 current FL-2 dated 7-6-17 revealed: diagnoses of methicillin resistant staphylococcus, dureus infection, Bacteremia, muscle weakness, lack of coordination; difficulty walking; obstructive and reflux uropathy, hypothyroidism, hyperlipidemia, hypertension, coronary artery disease, atrial fibrulation, diastolic congestive heart failure, gastroesophageal reflux disease. Review of resident care notes for Resident #2, progress notes revealed: -Resident #2 was vomiting blood and sent to the Emergency Room on 5-21-2017 and admitted to the hospital.	D 358		

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D 358	Continued From page 12 -Resident #2 was discharged from the hospital to a rehab facility and returned to the facility on 7-7-2017. Review of Delivery Manifest from pharmacy revealed: -Remeron (Mirtazapine 15mg tab, #15) was delivered for Resident #2 on 7-7-2017 at 10:50 PM. -Remeron (Mirtazapine 15mg tab, #15) was delivered for Resident #2 on 8-11-2017 at 12:33 PM. Review of the July 2017 electronic medication administration record (MAR) for Resident #2 revealed: -There was an entry for Mirtazapine (Remeron) Tablet 7.5 mg, give 1/2 tablet by mouth at bedtime for depression, discontinue date 7-18-2017. -Resident #2 received Mirtazapine (Remeron) Tablets 7.5 milligram for 10 days from 7-8-2017 to 7-17-17 at 9:00 PM. Review of the electronic medication administration record (MAR) for Resident #2 revealed there was no entry for Mirtazapine (Remeron) Tablet 7.5 mg. Review of medication orders and subsequent orders in Resident Record for Resident #2 revealed: -There was no medication order in the record for Mirtazapine (Remeron) 7.5 milligram tablets. -There was no discontinue order in the record for Mirtazapine (Remeron) 7.5 milligram tablets. Review of the pharmacy review dated 07/13/17 revealed: Remeron 7.5 milligrams at bedtime order was not in chart.	D 358		

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D 358	Continued From page 13 Observation of the medications on hand for Resident #2 on 08/16/17 revealed: -A supply of 12 Mirtazapine (Remeron) 7.5 milligram tablets were located on the medication cart. -A total of 3 Mirtazapine (Remeron) 7.5 milligram tablets had been punched from the packet with no documentation on the MAR of the medication being given. Review of medication orders and subsequent orders in Resident Record for Resident #2 revealed: -There was no medication order in the record for Mirtazapine (Remeron) 7.5 milligram tablets. -There was no discontinue order in the record for Mirtazapine (Remeron) 7.5 milligram tablets. -Medication review by pharmacist dated 7-13-2017 noted Remeron 7.5 milligrams at bedtime order was not in chart. Interview with Health and Wellness Director (HWD) on 8-16-17 at 8:45 AM revealed: -She was unable to locate an order or discontinue order for Mirtazapine 7.5 milligrams tablets in the resident record for Resident #2. -HWD was unable to account for the 3 missing pills in the pack of 30 for Resident #2. -HWD called the pharmacy who had an order dated 7-6-2017 for the following medications-Remeron 7.5 milligrams, 1 tablet by mouth at bed time, #30 tablets dispensed. -HWD requested a faxed copy of order for Mirtazapine (Remeron) 7.5 milligram tablets for Resident #2 and the delivery manifests for July and August, 2017 from the pharmacy for Resident #2. Telephone interview with Supervisor-In-Charge	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064008	A. BUILDING: _____ B. WING _____	R 08/16/2017

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D 358	Continued From page 14 (SIC) on 8-16-2017 at 12:26 PM revealed: -SIC worked on 2nd shift. -Resident #2 just started taking Mirtazapine (Remeron) last week and takes it at bedtime. -SIC pulled the medication, gives the medication to Resident #2 and then documents it on the MAR. -SIC did not recall giving Resident #2 any Mirtazapine in July. -She did not know who orders the medications. -If she had seen the medication on the MAR, she would have given the medication. Telephone interview with SIC/RA on 8-16-2017 at 12:31 PM revealed: -She did not recall giving Resident #2 any Mirtazapine (Remeron). -Resident #2 went to Rehab and got out about 2 weeks ago. -When Resident #2 returned to the facility, Mirtazapine was prescribed for her. -SIC/RA does not think she saw Mirtazapine on the MAR, but the medication was on the cart. -She denied giving the medication to Resident #2. -When medications come in at night, she will scan the medication in. Telephone interview with Pharmacy Technician on 8-17-2017 at 12:41 PM revealed: -The facility has the Point Click Care System. -The facility has to enter the orders in the system for the electronic (MAR) to be correct. -The pharmacy did not send an updated MAR with the medication. -The facility had to enter the orders in the system for refills. -The facility sent the original order for Mirtazapine for Resident #2 on 7-7-2017 as shown on the heading of the faxed order requested by the HWD on 8-16-2017.	D 358		

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D 358	Continued From page 15 Telephone interview with Pharmacist on 8-17-2017 at 3:38 PM to get clarification of Medication Review dated 7-13-2017 revealed: -Pharmacist conducted Medication Review noted order for Remeron 7.5 mg QHS was NIC (not in chart) and the facility was made aware as the medication was either on the cart or on the dispensing record and no order was located in the file.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure the County Department of Social Services be notified of any accident or incident resulting in injury to resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid for 1 of 5 residents (#3). The findings are: Review of FL-2 dated 4-26-17 for Resident #3 revealed diagnoses of vitamin D deficiency, memory loss, edema, depression, GERD, and	D 451		

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D 451	Continued From page 16	D 451		

hypothyroidism.

Review of FL-2 addendum dated 4-26-17 for Resident #3 revealed: additional diagnosis of edema to both feet, decrease memory, behavior problems with dementia, inappropriate behaviors at times, recent falls.
-Resident #3 was using a walker for ambulation.
-Resident #3 would benefit from Physical therapy and Occupational therapy

Review of personal care log for Resident #3 revealed:
-On 5-4-17 at 10:30 AM Resident #3 was trying to get into recliner chair and hit head on the wall. Resident #3 was sent to the emergency room (ER).
-On 6-7-17 at 7:30 AM Resident #3 was transferring from wheelchair to recliner and loss balance resulting in a fall. Resident hit buttocks and complained of pain in upper right thigh. Resident #3 was unable to transfer and complained of increased leg pain at 11:30 am. Resident #3 was sent to the ER.

Phone interview with Health and Wellness Director (HWD) on 8-17-17 at 11:44 am revealed:
-When the staff are made aware of an accident or incident, staff will assess the resident.
-Family is contacted.
-Medical provider is contacted.
-Resident will be sent out to ER if needed.
-Information is sent to the cooperate office.
-HWD stated that she was unaware that she was to forward the reports to DSS.

Review of facility incident and accident report revealed: there was notification of accident and incident made to Nurse, Family, Physician, and Police if required.

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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 all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure that 1 of 5 sampled residents (Resident #3) requiring supervision were being supervised according to their care plan and needs and resulting in 7 falls in 4 months.[Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).]	D912		