STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041079	A. BUILDING: _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE GREENS	803 MEADOWOOD STREET GREENSBORO, NC 27409

(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 October 27, 2021-October 28, 2021.	D 000		
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, record reviews, and interviews the facility failed to ensure clarification of medication orders for 1 of 5 residents sampled (#4) who had orders for an as needed pain medication. The findings are: Review of Resident #4's current FL2 dated 08/19/21 revealed: -There was a order for oxycodone 5mg ½ tablet 4 times daily as needed. -There was an order for oxycodone 5mg 1 tablet four times daily as needed.	D 344		

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D 344	Continued From page 1	D 344		

Review of Resident #4's physician's order dated 08/24/21 revealed an order for oxycodone 5mg tablet take a half tablet every 6 hours as needed for mild to moderate pain; take 1 tablet every 6 hours as needed for severe pain.

Review of Resident #4's electronic Medication Administration Record (eMAR) for August 2021 revealed:
-There was an entry for oxycodone 5mg tablet take a half tablet (2.5mg) every 6 hours as needed for mild to
moderate pain. Take two half tablets (5mg) every 6 hours as needed for severe pain.
-Oxycodone was documented as administered on 08/29/21 through 08/31/21.
-There was no documentation if a half tablet or 2 half tablets were administered or documentation of Resident #4's pain level.

Review of Resident #4's eMAR for September 2021 revealed:
-There was an entry for oxycodone 5mg tablet take a half tablet (2.5mg) every 6 hours as needed for mild to
moderate pain. Take two half tablets (5mg) every 6 hours as needed for severe pain.
-Oxycodone was documented as administered on 09/01/21, 09/03/21, 09/06/21, 09/08/21, 09/09/21, 09/20/21, 09/28/21 and 09/29/21.
-There was no documentation if a half tablet or 2 half tablets were administered or documentation of Resident #4's pain level.

Review of Resident #4's eMAR for October 2021 revealed:
-There was an entry for oxycodone 5mg tablet take a half tablet (2.5mg) every 6 hours as needed for mild to
moderate pain. Take two half tablets (5mg) every

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	HAL041079	A. BUILDING: _____ B. WING _____	10/28/2021

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D 344	Continued From page 2	D 344		

6 hours as needed for severe pain.
-Oxycodone was documented as administered on 10/02/21 and 10/04/21.
-There was no documentation if a half tablet or 2 half tablets were administered or documentation of Resident #4's pain level.

Observation of Resident #4's medications on hand on 10/28/21 at 2:01pm revealed:
-Oxycodone 5mg was available for administration with directions to take a half tablet every 6 hours as needed for mild to moderate pain. Take two half tablets every 6 hours as needed for severe pain.
-Oxycodone was dispensed by the pharmacy on 08/24/21 with a quantity of 40 half tablets and there were 26 half tablets remaining.

Interview with Resident #4's pharmacy on 10/28/21 at 3:34pm revealed:
-Resident #4 had an order for oxycodone 5mg with directions to take a half tablet every 6 hours as needed for mild to moderate pain. Take two half tablets every 6 hours as needed for severe pain.
-Oxycodone 5mg was dispensed to the facility on 08/24/21 with a quantity of 20 half tablets.
-The order for oxycodone was entered on the eMAR as it was written by Resident #4's physician.
-Most Assisted Living facilities did not use pain scales, but that was up to the physician and the facility.

Interview with Resident #4 on 10/28/21 at 3:13pm revealed:
-She had pain in her leg and was prescribed oxycodone for her pain.
-She never took oxycodone unless her pain was at least an 8 of 10.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041079	A. BUILDING: _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 344	Continued From page 3 -The last time she was administered oxycodone was on a day when she had physical therapy and skilled nursing services on the same day which cause her increased pain in her leg. -She asked for oxycodone when she needed it and let the medication aides (MA) know how bad her pain was. -MAs did not ask any questions about her pain. -If she asked for oxycodone, she was in "dire need". -MAs administered her half tablets each time she asked for oxycodone. -She was never administered 2 half tablets. -When she was administered oxycodone, it did not take the pain away, but it made it bearable. Interview with a MA on 10/28/21 at 3:00pm revealed: -Resident #4 was administered oxycodone for pain. -There were no instructions for administering oxycodone except for a half tablet for mild to moderate pain and 2 half tablets for sever pain. -The order for oxycodone was more for a skilled nursing facility. -MAs did not have the skill set to determine Resident #4's pain level. -She had not called Resident #4's primary care provider (PCP) to get the order for oxycodone clarified. Interview with a MA on 10/28/21 at 3:07pm revealed: -Resident #4 had orders for oxycodone for pain in her leg. -The order for oxycodone was a half tablet for mild to moderate pain and 2 half tablets for severe pain. -Resident #4 told her she needed oxycodone once.	D 344		

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D 344	Continued From page 4 -Resident #4 told her that her pain was not bad and that she just wanted something to calm the pain in her leg. -She did not use any type of tool or pain scale to assess Resident #4's pain. -She administered oxycodone to Resident #4 according to what she told her. Interview with a MA on 10/28/21 at 3:19pm revealed: -Resident #4 had an order for oxycodone for pain. -If Resident #4 asked for oxycodone, she would ask Resident #4 what her pain level was from 0 to 10. -If Resident #4 indicated her pain was a 6 or above, that would be severe pain and she would administer 2 half tablets for severe pain. -If Resident #4's pain was below 6, she would administer a half tablet. Interview with the Resident Care Coordinator (RCC) on 10/28/21 at 3:24pm revealed: -She was responsible for reviewing new orders for residents and clarifying orders as needed with the resident's physician. -If she was not in the facility, MAs reviewed and clarified new orders. -She was not in the facility when Resident #4's order for oxycodone was received. -She just saw the order for Resident #4's oxycodone today on 10/28/21. -She would have clarified the order for oxycodone if she had known about it. -The MA who received the order for oxycodone should have clarified the order because staff could not determine whether they needed to give a half tablet or 2 half tablets. -The order for oxycodone was like two orders in one.	D 344		

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	HAL041079	A. BUILDING: _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE GREENS	803 MEADOWOOD STREET GREENSBORO, NC 27409

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D 344	Continued From page 5 Interview with the Administrator on 10/28/21 at 4:21pm revealed: -The MAs were initially responsible for clarification of orders and the RCC should review and clarify medication orders as well. -She did not know about Resident #4's physician's order for oxycodone. -If the order for oxycodone was confusing, she would have expected a MA and the pharmacy to clarify the order with Resident #4's PCP. -She did not know if anyone had followed up with Resident #4's PCP. Attempted interview with Resident #4's PCP on 10/28/21 at 2:43pm was unsuccessful.	D 344		
D 484	10A NCAC 13F .1501(c) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And ALternatives (c) In addition to the requirements in Rules 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements: (1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend.	D 484		

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	HAL041079	A. BUILDING: _____ B. WING _____	10/28/2021

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D 484	Continued From page 6 (2) The assessment shall include consideration of the following: (A) medical symptoms that warrant the use of a restraint; (B) how the medical symptoms affect the resident; (C) when the medical symptoms were first observed; (D) how often the symptoms occur; (E) alternatives that have been provided and the resident's response; and (F) the least restrictive type of physical restraint that would provide safety. (3) The care plan shall include the following: (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained; (B) the type of restraint to be used; and (C) care to be provided to the resident during the time the resident is restrained. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure documentation of an assessment for the use of bedrails and care planning through a team process and attempted alternatives prior to the use of restraints for 1 of 1 sampled resident (Resident #1) with half bedrails. The findings are: Review of Resident #1's current FL2 dated	D 484		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 484	Continued From page 7 03/16/21 revealed: -Diagnoses included fracture of part of the left clavicle, chronic kidney disease, glaucoma, and muscle weakness. -She was intermittently disoriented. -She was semi-ambulatory. -There was no order for bedrails. Review of Resident #1's physician's orders dated 06/10/21 revealed: -Resident #1 was admitted to hospice care on 04/13/21. -There was an order for a hospital bed with half rails. Review of Resident #1's physician's orders dated 10/27/21 revealed: -Resident #1 was admitted to hospice care on 04/13/21. -There was an order for a hospital bed with half rails related to weakness and fatigue. Review of Resident #1's care plans dated 04/13/21 and 10/01/21 revealed: -She needed escorting and physical assistance to attend to meals and daily activities. -A gait belt was used as a transfer enabling device. -Orientation and confusion interfered with her daily functioning. -Resident #1 had no impairments with her ability to communicate and understand. -Staff would provide some or complete physical assistance to Resident #1 during times of mobility as needed. -Staff would check on Resident#1's whereabouts and safety regularly throughout the day, around the clock: 4 safety checks per shift. -There was no information regarding need for or use of bedrails on either the 04/13/21 or 10/01/21	D 484		

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VERRA SPRINGS AT HERITAGE GREENS	803 MEADOWOOD STREET GREENSBORO, NC 27409

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D 484	Continued From page 8 care plan. -The care plans were not signed by the responsible party/family member. Review of Resident #1's Licensed Health Professional Support (LHPS) review dated 08/13/21 revealed the use of a bedrail was not documented. Review of Resident #1's record revealed: -There was no assessment or quarterly assessment for the use of bed rails. -There was no consent from the responsible party for the use of bedrails. Review of a typed document provided by the Resident Care Coordinator (RCC) on 10/28/21 revealed: -The document was not signed or dated. -There was documentation as of 06/10/21, the responsible party granted permission for Resident #1 to use half-rails on her bed. -The responsible party's name was typed in the signature space. Review of Resident #1's occupation therapy (OT) note dated 08/12/21 revealed Resident #1 worked on bed mobility rolling side to side with the use of bed rails. Review of Resident #1's physical therapy (PT) notes dated 08/11/21, 08/16/21, and 08/17/21 revealed: -Resident #1 required maximum assistance of verbal and tactile cues to transition from lying on her back to sitting and shifting her legs to the edge of the bed using her elbow or bed rail to pull up. -Resident #1 required increased time to reposition in bed with use of bedrail to transition to the head of the bed.	D 484		

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	HAL041079	A. BUILDING: _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE GREENS	803 MEADOWOOD STREET GREENSBORO, NC 27409

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D 484	Continued From page 9 Review of Resident #1's PT note dated 08/23/21 revealed Resident #1 required moderate assistance using bedrail to transition from lying on her back to the edge of the bed. Review of Resident #1's physical therapy discharge summary dated 08/30/21 revealed: -Resident #1 had functional deficits in bed mobility: rolling side to side, bridging/scooting, lying on back to sitting, and sitting to lying on back. -Resident #1 continued to require assistance for bed mobility. Observation of Resident #1 during the initial tour of the facility on 10/27/21 at 9:50pm revealed: -Resident #1 was lying in a hospital bed positioned almost in the center of the bedroom. -Both one-half length bedrails were in the up position on the hospital bed. -Resident #1 was sitting up at a 45-degree angle in the hospital bed. -Resident #1 did not make any positional changes or attempt to get out of the bed. he bed. Observations of Resident #1 at various times on 10/28/21 revealed: -At 8:30am, Resident #1 was sitting up in her hospital bed at about a 45-degree angle with both one-half bedrails up on each side of the bed. -At 11:48am, Resident #1 was sitting up in her hospital bed at about a 75-degree angle with both one-half bedrails up on each side of the bed. Interview with Resident #1 on 10/27/21 at 9:49am revealed: -She did not know why she had bedrails on her hospital bed or how long she had them.	D 484		

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D 484	Continued From page 10	D 484		

-She used the bedrails sometimes to turn over in the bed when staff provided personal care.
-The bedrails were up on both sides of the bed most of the time, but staff put the rail down to provide personal care.
-She did not get out of the bed, because she could not walk.
-Sometimes she snuck out of bed and used her seated walker, but she could not explain how she got out of the bed.
-She was able to eat independently, but she needed staff to set up her meals.
-She required staff assistance for all other activities of daily living.

Interview with a personal care aide (PCA) on 10/28/21 at 4:00pm revealed:
-She did not know why Resident #1 had bedrails.
-Resident #1 could not reposition in bed by herself.
-She needed the assistance of staff and used the bedrails to help her turn.
-Resident #1 had shorter rails previously, but she did not remember when.
-She did not know if Resident #1 was able to put the bedrails down by herself.
-She did not know if there had been an assessment or quarterly assessments for bedrails completed for Resident #1.

Interview with a medication aide (MA) on 10/28/21 at 4:03pm revealed:
-Resident #1 had bedrails to position in bed.
-She did not know how long Resident #1 had bedrails, but the bedrails were in place when she started working at the facility in June 2021.
-Resident #1 did not try to get out of bed by herself.
-She did not know if there had been an assessment or quarterly assessments for bedrails

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D 484	Continued From page 11 completed for Resident #1. Interview with the Resident Care Coordinator (RCC) on 10/28/21 at 4:07pm revealed: -Resident #1's care plan was updated in April 2021 after she was admitted to hospice services on 04/13/21. -Resident #1 received her hospital bed and bedrails through her hospice provider in June 2021. -Resident #1 had the half bedrails because she had declined mentally, her mobility declined, and she could easily fall off her bed. -PT trained her on how to use the bedrails. -She did not know an assessment was needed prior to residents using bedrails and quarterly. -Resident #1's responsible party gave consent for the bedrails through her hospice provider. -The facility had not consulted with Resident #1's family member for consent to use the bedrails prior to use. -Staff put the bedrails down on one side when providing personal care to Resident #1. Interview with the Administrator on 10/28/21 at 4:21pm revealed: -Resident #1 used on-half bedrails because she was on hospice and the bedrails were used at end of life for positioning. -Resident #1 was the only resident in the facility with bed rails. -She did not know an assessment was needed prior to the use of bedrails and quarterly as well as documentation of consent from the responsible party. Attempted telephone interviews with Resident #1's hospice provider on 10/27/21 at 2:42pm and on 10/28/21 at 1:19pm were unsuccessful.	D 484		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 484	Continued From page 12 Attempted telephone interview with Resident #1's family member on 10/28/21 at 1:57pm was unsuccessful.	D 484		