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
	HAL088015	A. BUILDING: _____ B. WING _____	R 07/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 and follow-up survey and complaint investigation on 07/19/21 and 07/20/21.	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 B VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) related to two incidents of elopement from the special care unit (SCU) through a window. The findings are: Review of the facility's Missing Resident/Resident Elopement Standard Operating Procedure dated 07/24/19 revealed: -A. A resident will be deemed missing and/or to have eloped when all the following conditions are met: the resident is not present in the community, the resident's whereabouts cannot be readily determined, and there is reason to be concerned for the resident's safety or wellbeing. -B. If a resident is deemed missing and/or to have eloped, the community shall take the following actions: -Check the sign-in/sign-out log to determine if the	D 270		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Clay E. Elliott — TITLE: Administrator — (X6) DATE: 8/24/21

Reviewed and acknowledged 8/25/21

RP

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D 270	Continued From page 1 resident was recently signed in or out. -Perform a physical search of the community interiors, including every room. Locked space, vestibule, and common area, as well as the immediate outside areas. -Call the resident's designated responsible party, family member, guardian, and /or Power of Attorney (POA) as may be applicable to confirm the resident is not with a resident representative and notify the resident representative of the event. -Promptly notify all community staff of the event, including the Supervisor and the Executive Director (ED). -If the resident is not found within thirty minutes of being deemed missing/to have eloped, the ED or Supervisor must immediately notify the following individuals/entities: Local Law Enforcement, the community's compliance-monitoring or licensing agency and the Divisional Vice President of Operations for the facility. Review of Resident #1's current FL2 dated 02/05/21 revealed: -Recommended level of care was domiciliary - special care unit. -Diagnoses included dementia. Review of Resident #1's Resident Registrar revealed Resident #1 was admitted to the facility on 08/24/20. Review of Resident #1's record revealed no documentation of an elopement risk assessment. Review of Psychiatry Progress notes regarding Resident #1 dated 06/07/21 revealed Resident #1 remained frustrated about being at the facility and was trying to make plans to leave.	D 270		

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D 270	Continued From page 2 Interview with Resident #1 on 07/19/21 at 9:37am revealed: -She had been "locked in" this facility for 10 months. -She left the facility last week by climbing out a window. -This was the second time she left the facility by climbing out a window. -The police picked her up on the road when she was out of the facility the previous week. -She had to use the window because staff locked all the doors and she was unable to leave. Review of a facility event report dated 06/12/21 revealed: -Resident #1 was alone and outside on facility grounds. -No injury was noted to Resident #1. -As an intervention, Resident #1 was put-on 24-hour supervision for 72 hours. -She also had a medication review with an increase in her Zoloft from 25mg to 50mg. -The Primary Care Provider (PCP) ordered Ativan 0.5mg as needed every eight hours for agitation and anxiety. Review of a facility event report dated 07/14/21 revealed: -Resident #1 was unable to be located in the facility. -Resident #1 was transported to the local hospital by staff from the local police department. -Resident #1 was cleared medically and returned back to the facility. -As an intervention, Resident #1 was put on one on one observation for 24 hours. -The windows in the building were checked and were secured. -Resident #1 was moved to a room with courtyard access.	D 270		

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D 270	Continued From page 3 -The courtyard could be monitored from offices and the dayroom. -The courtyard had a six-foot fence and a code locked door. Interview with a housekeeper on 07/20/21 at 9:37am revealed: -On 06/12/21, he was on hall 100 and saw Resident #1 walking outside by the exit door. -He asked a Personal Care Aide (PCA) if Resident #1 was supposed to be outside. -The PCA told him Resident #1 was not supposed to be outside by herself. -He immediately went to the exit door on hall 100 and the PCA immediately went to the front door. -They went outside and found Resident #1 by herself in the parking lot. -Resident #1 told him she wanted to go to the library. -He had not had training on what to do in case of an elopement. Interview with a PCA on 07/20/21 at 10:02am revealed: -On 06/12/21, one of the housekeepers asked her if Resident #1 could be outside. -She told him no. -The housekeeper told her he had seen Resident #1 walking outside past the exit door on hall 100. -They both went outside and found Resident #1 almost out of the parking lot and heading toward the apartments across the road. -Resident #1 was easily redirected to come back inside the facility. -Resident #1 told her and the housekeeper that she wanted to go to the library. -She reported it to the medication aide (MA) who called the Administrator. -She was not sure what happened after that. -She had never had training on what to do if a	D 270		

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D 270	Continued From page 4 resident eloped. Interview with the MA Lead Supervisor on 07/19/21 at 1:10pm revealed: -Resident #1 was upset on the morning of 07/14/21. -Resident #1 had been telling them that morning she was going to leave. -One of the PCA's was assigned to monitor Resident #1's location every fifteen minutes. -The PCA reported that Resident #1's roommate had asked for a blanket while Resident #1 appeared to be sleeping. -When the PCA returned, Resident #1 was gone. -The window was open, and the screen was off. -Staff began checking all the rooms. -Staff began checking outside the facility. -She was gone about 20 minutes before she was found by the police. Interview with the Memory Care Manager (MCM) on 07/19/21 at 3:09pm revealed: -On 07/14/21, Resident #1 was upset and thought that staff was lying to her. -Around 10:00am, they placed Resident #1 on fifteen minutes checks. -The PCA assigned to monitor Resident #1 went to her room and thought she was pretending to be asleep. -When the PCA came back to the room less than 15 minutes later, Resident #1 was gone. -He was aware Resident #1 had gotten outside on 06/12/21 but he thought this was an isolated incident. Telephone Interview with a Detective with the local Police Department (PD) on 07/19/21 at 4:53pm revealed: -The local PD received a 911 call regarding a missing female resident from the facility.	D 270		

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D 270	Continued From page 5 -Resident #1 was found walking in a residential neighborhood one mile from the facility on 07/14/21. -Resident #1 seemed very lucid and stated she wanted to make a complaint against the facility. -Resident #1 was taken to the police department and made a complaint against the facility. -Resident #1's POA was contacted and reported Resident #1 had dementia and should be returned to the facility. -Adult Protective Services (APS) was contacted and took Resident #1 to the hospital to be evaluated. -They could not determine any type of neglect based on the complaint Resident #1 filed against the facility. Telephone interview with the previous Administrator on 07/19/21 at 6:30pm revealed: -On 06/12/21, when Resident #1 was seen outside, she did not consider that an elopement because the housekeeper and the PCA "had eyes on her" while she was outside. -The housekeeper went out the side door and the PCA went out the front door and escorted Resident #1 back inside the building. -The staff determined Resident #1 had gone to another residents' room on another hall and opened the window, popped the screen out and exited the facility. -Resident #1 was put on one to one observation for 24 hours, then 15 minutes checks for the next two or three days. -Resident #1 had some medication changes after this incident and it "seemed to settle her down." -Resident #1 would often say "ya'll are holding me prisoner." -On 07/14/21, Resident #1 came into her office that morning. -Resident #1 was very upset and cursed at her.	D 270		

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D 270	Continued From page 6 -A PCA had been assigned to check on Resident #1 every fifteen minutes. -The PCA went to the linen closet to get a blanket for Resident #1's roommate, and when she returned Resident #1 was gone. -The PCA observed the window was opened and the screen was removed. -The staff searched the entire building for her and made sure all other residents were accounted for. -She called 911. -She and 5 other staff members began searching outside. -She left the facility and began driving toward the library. -Two police officers were talking with Resident #1 on the side of the road. -She followed the officers back to the police department where Resident #1 filed a complaint against the facility stating she had been assaulted. -She refused to allow Resident #1 in her vehicle to return her to the facility since she had accused an unidentified staff member of assault. -APS was called and came to the police department and took her to the hospital to be examined. -She returned to the facility and was not present when Resident #1 returned and was not aware what happened as she left employment with the facility at approximately 3:00pm. Interview with the Special Care Coordinator (SCC) on 07/20/21 at 8:41am revealed on 07/14/21, after Resident's #1's elopement from the facility and evaluation at the hospital, he transported her back to the facility. Telephone interview with the Administrator on 07/20/21 at 10:02am revealed: -She became the Administrator of the facility on	D 270		

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D 270	Continued From page 7 07/14/21. -She had not been to the facility yet but planned on coming on 07/22/21. -She was aware of the incident that had occurred on 07/14/21 with Resident #1. -She expected staff to investigate why this occurred and develop a plan to prevent it from happening again. Attempts were unsuccessful to contact the staff that reported Resident #1 missing on 07/14/21. The facility failed to provide supervision to a resident (#1) who eloped from the facility on two different occasions from a window in the special care unit resulting in one emergency room visit for evaluation. This failure was detrimental to the health, safety and well-being to the resident and constitutes a Type B Violation. The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 07/20/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 03, 2021.	D 270		
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	D 276		

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D 276	Continued From page 8 Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement an order for 1 of 5 sampled residents (#4), related to an order for the application and removal of Thromo-Embolus Deterrent (TED) hose. The findings are: Review of Resident #4's current FL2 dated 02/09/21 revealed: -Diagnoses included dementia, chronic obstructive pulmonary disease (COPD), acute rhabdomyolysis (breakdown of muscle tissue that releases dangerous protein into the blood) and chronic kidney disease. -An order for Thromo-Embolus Deterrent (TED) Hose (helps to prevent blood clots), on in the morning and off in the evening. Review of Resident #4's electronic Medication Administration Record (eMAR) for June 2021 and July 2021 revealed: -There was an entry for TED hose put on in the morning with an application time of 8:00am. -There was documentation the TED hose were applied at 6:00am from 06/01/21 - 07/01/21 at 6:00am. -There was an entry for TED hose remove at bedtime with a removal time of 8:00pm. -There was documentation the TED hose were removed at 8:00pm from 06/01/21 - 07/01/21 at 8:00pm. Observation of Resident #4 on 07/19/21 at 9:23am revealed: -The resident was sitting in a recliner in her room. -The resident had socks and shoes on.	D 276		

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D 276	Continued From page 9 -The resident was not wearing TED hose. Observation of Resident #4 on 07/19/21 at 12:56pm revealed: -The resident was sitting in a recliner in her room. -The resident had socks and shoes on. -The resident was not wearing TED hose. Interview with Resident #4 on 07/19/21 at 12:56pm revealed: -She did not have her TED hose on. -She did have TED hose to put on. -She did not know why staff had not put them on. Interview with a Medication Aide on 07/19/21 at 1:13pm revealed: -Resident #4 did not have her TED hose on. -Third shift was responsible for applying the resident's TED hose and the second shift MA was responsible for removing them. -Resident #4 did not always want to wear her TED hose as she did not like them and said they were to tight. Observation of Resident #4 on 07/20/21 at 9:42am revealed: -The resident was sitting in a recliner in her room. -The resident had socks and shoes on. -The resident was not wearing TED hose. -Two staff members were assisting the resident in applying her splint to her left arm. Interview with the Special Care Coordinator (SCC) on 07/20/21 at 9:47am revealed: -Resident #4 had a current order for TED hose. -Staff should be applying TED hose daily and documenting accordingly. Interview with the Licensed Health Professional Staff (LHPS), on 07/20/21 at 10:02am revealed:	D 276		

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D 276	Continued From page 10 -She had not observed an order for TED hose to be discontinued. -She usually found out about changes with the residents by word of mouth or texting. -She would also review the resident record for falls, medication and order changes, progress notes, therapy notes and labs. -She had completed her review of Resident #4 on 07/01/21 and documented she had no task as she had been told by the SCC that the TED hose were on hold and were being discontinued. -Resident #4 had not been wearing TED hose since her assessment and she had noticed she still did not have them on 07/20/21. -She was not aware Resident #4's TED hose order had not changed and she should be wearing the TED hose. Interview with a Personal Care Assistant (PCA) on 07/20/21 at 10:53am revealed Resident #4 did not wear her TED hose several times a week. Interview with the PCA on 07/20/21 at 11:00am revealed: -She had assisted Resident #4 with her arm brace this morning. -Resident #4 had her gripper socks on with shoes but did not have on TED hose. -The MAs were responsible for applying and removing the TED hose. Interview with the SCC on 07/20/21 at 11:10am revealed: -The MAs were responsible for applying and removing the TED hose for Resident #4. -The MAs were also responsible to document on the eMAR if the applied the TED hose or if not place a note under the notes in the eMAR. -There was a specific section on the eMAR labeled "other" if for any reason they could not	D 276		

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D 276	Continued From page 11 apply the TED hose for the resident. -Staff should not be documenting they were applying the TED hose if they were not. Interview with the Administrator on 07/20/21 at 11:38am revealed: -She had been the Administrator since 07/14/21. -She was scheduled to be at the facility for the first time on 07/22/21. -She was not familiar with Resident #4. -The process was for the MAs to be responsible for applying and removing the TED hose for the resident. Telephone interview with a second MA on 07/20/21 at 2:00pm revealed: -She had documented she had applied the TED hose on the eMAR when she had not because she had been taught to document she had put them on daily with the exception of when the resident refused. -She was to document the refusal but nothing else. -She knew that was not the correct way to document but that was what she had been trained to do. -She had been trained by another MA. Attempted interview with the Nurse Practitioner (NP) on 07/20/21 at 2:30pm was unsuccessful.	D 276		
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:	D 358		

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D 358	Continued From page 12 (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 administer medications as ordered by a licensed prescribing practitioner for 1 of 6 residents (Resident #6) observed during the medication pass related to a medication to treat agitation. The findings are: The medication error rate was 4% as evidenced by the observation of 1 error out of 28 opportunities during the 11:30am/12:00pm medication pass on 07/19/21 and the 8:00am/9:00am medication pass on 07/20/21. Review of Resident #6's FL2 dated 02/12/21 revealed: -Diagnoses included dementia, major depressive episodes, and chronic obstructive pulmonary disease. -There was an order for sertraline (used to treat agitation) 50mg 1 tablet daily. Review of Resident #6's mental health provider (MHP) visit note dated 02/15/21 revealed: -There was an order to discontinue sertraline 50mg daily. -There was an order to start sertraline 75mg daily for agitation. Review of Resident #6's MHP visit note dated 07/15/21 revealed a prescription for sertraline 50mg take one and a half tablets daily had been sent to the contracted facility pharmacy by	D 358		

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D 358	Continued From page 13 Resident #6's Nurse Practitioner (NP). Observation of the 8:00am medication pass on 07/20/21 revealed: -The Medication Aide (MA) prepared Resident #6's medications according to the electronic Medication Administration Record (eMAR) for 8:00am medications. -There was no sertraline available for administration to Resident #6 on the medication cart. Review of Resident #6's July 2021 eMAR revealed: -There was an entry for sertraline 50mg take one and a half tablets once a day scheduled at 8:00am. -Sertraline 75mg was documented as administered once daily from 07/01/21 to 07/15/21 and 07/19/21 to 07/20/21. -The sertraline was documented as not administered from 07/16/21 to 07/18/21. Interview with the MA on 07/20/21 at 9:15am revealed: -Resident #6's medications were packaged in multi-dose unit packaging. -Resident #6's sertraline had recently been packaged separately in a bubble pack. -Medications packaged in bubble packs were supposed to be reordered from the pharmacy by the MAs 7 days before the medication would run out. -To reorder a medication, the MAs took the label off the top of the bubble pack and faxed the request to the pharmacy for a refill. -There were MAs assigned to audit the medication carts every weekend. -The audits included checking the medications on hand against entries on each residents eMAR.	D 358		

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D 358	Continued From page 14 -The Special Care Coordinator (SCC) also conducted weekly medication cart audits to ensure medications were available for administration. Telephone interview with the contracted facility pharmacy on 07/20/21 at 9:26am revealed: -A week's supply of sertraline would arrive on 07/21/21 for Resident #6 in the resident's multi-dose unit packaging. -The sertraline had recently required a prescription to refill the medication. -The pharmacy dispensed 10 and a half tablets of sertraline 50mg on 07/15/21, so the facility would have enough medication until the multi-dose unit package arrived on 07/21/21. Observation of Resident #6's sertraline bubble pack on 07/20/21 at 9:37am revealed: -The bubble pack contained 17 sertraline 50mg tablets. -The label directions were sertraline 50mg take 1 tablet every day with a quantity of 30 dispensed on 10/02/20. -The expiration date of the sertraline was 10/02/21. -There was a direction changed refer to chart sticker affixed to the top of the bubble pack label. Interview with the MA on 07/20/21 at 10:15am revealed: -She had found one bubble pack of sertraline 50mg tablets for Resident #6 in the medication room. -The bubble pack of sertraline was "old," so she had not used it nor had she stored it in the medication cart for others to use. -She had borrowed a dose of sertraline from another resident and administered it to Resident #6.	D 358		

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D 358	Continued From page 15 -She had spoken with the pharmacy and Resident #6's sertraline would arrive tomorrow (07/21/21) packaged in the multidose unit packaging. Interview with the SCC on 07/20/21 at 11:45am revealed: -He had been unable to find Resident #6's sertraline the pharmacy dispensed on 07/15/21. -He called the pharmacy to find out which staff had signed to accept the medication upon delivery. -The pharmacy was "now" saying sertraline was not sent for Resident #6 on 07/15/21. -The pharmacy said they had waited to send the sertraline. -The pharmacy would add the sertraline to the multi-dose unit packages to start 07/21/21. Telephone interview with Resident #6's MHP NP on 07/20/21 at 2:05pm revealed: -Facility staff had paged her on 07/15/21 requesting a refill for Resident #6's sertraline. -She sent a new prescription for the sertraline to the pharmacy on 07/15/21. -Facility staff did not let her know they had not received the sertraline from the pharmacy and Resident #6 had missed the sertraline on 07/16/21 through 07/18/21. -Abruptly discontinuing sertraline could make the resident more agitated and anxious. -Resident #6 was not on a "real" high dose of sertraline. -She had not received any reports of increased agitation and anxiety from staff concerning Resident #6, but the resident should not have missed the doses of sertraline. Interview with the SCC on 07/20/21 at 2:50pm revealed:	D 358		

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D 358	Continued From page 16 -Staff had followed the facility policy by contacting the pharmacy the day before the last dose was to be used. -Staff discovered the sertraline required a prescription to obtain a refill. -Staff contacted the MHP to obtain the prescription. -The MHP sent in a new prescription for the sertraline on 07/15/21. -The next day when the staff administered the last dose of sertraline, they "should have" placed a stat order with the pharmacy. -A stat order would have been delivered by the pharmacy by 12 midnight and available for administration the next morning. -He had obtained a prescription from Resident #6's MHP for doses of sertraline to repay the doses staff had borrowed from the other resident on 07/19/21 and 07/20/21. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	D 367		

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D 367	Continued From page 17 documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the electronic Medication Administration Record (eMAR) was accurate for 1 of 5 sampled residents (#4) related to Thromo-Embolus Deterrent (TED) Hose. The findings are: Review of Resident #4's current FL2 dated 02/09/21 revealed: -Diagnoses included dementia, chronic obstructive pulmonary disease (COPD), acute rhabdomyolysis (breakdown of muscle tissue that releases dangerous protein into the blood) and chronic kidney disease. -An order for Thromo-Embolus Deterrent (TED) Hose (helps to prevent blood clots), on in the morning and off in the evening. Review of Resident #4's electronic Medication Administration Record (eMAR) for June 2021 and July 2021 revealed: -There was an entry for TED hose put on in the morning with an application time of 8:00am. -There was documentation the TED hose were applied at 6:00am from 06/01/21 - 07/01/21 at 6:00am.	D 367		

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D 367	Continued From page 18 -There was an entry for TED hose remove at bedtime with a removal time of 8:00pm. -There was documentation the TED hose were removed at 8:00pm from 06/01/21 - 07/01/21 at 8:00pm. Observation of Resident #4 on 07/19/21 at 9:23am revealed: -The resident was sitting in a recliner in her room. -The resident had socks and shoes on. -The resident was not wearing TED hose. Observation of Resident #4 on 07/19/21 at 12:56pm revealed: -The resident was sitting in a recliner in her room. -The resident had socks and shoes on. -The resident was not wearing TED hose. Interview with Resident #4 on 07/19/21 at 12:56pm revealed: -She did not have her TED hose on. -She did have TED hose to put on. -She did not know why staff had not put them on. Interview with a Medication Aide on 07/19/21 at 1:13pm revealed: -Resident #4 did not have her TED hose on. -Third shift was responsible for applying the resident's TED hose and the second shift MA was responsible for removing them. -Resident #4 did not always want to wear her TED hose as she did not like them and said they were to tight. Observation of Resident #4 on 07/20/21 at 9:42am revealed: -The resident was sitting in a recliner in her room. -The resident had socks and shoes on. -The resident was not wearing TED hose. -Two staff members were assisting the resident in	D 367		

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D 367	Continued From page 19 applying her splint to her left arm. Interview with the Special Care Coordinator (SCC) on 07/20/21 at 9:47am revealed: -Resident #4 had a current order for TED hose. -Staff should be applying TED hose daily and documenting accordingly. Interview with the Licensed Health Professional Staff (LHPS), on 07/20/21 at 10:02am revealed: -She had not observed an order for TED hose to be discontinued. -She usually found out about changes with the residents by word of mouth or texting. -She would also review the resident record for falls, medication and order changes, progress notes, therapy notes and labs. -She had completed her review of Resident #4 on 07/01/21 and documented she had no task as she had been told by the RCC that the TED hose were on hold and were being discontinued. -Resident #4 had not been wearing TED hose since her assessment and she had noticed she still did not have them on 07/20/21. -She was not aware Resident #4's TED hose order had not changed and she should be wearing the TED hose. Interview with a Personal Care Assistant (PCA) on 07/20/21 at 10:53am revealed Resident #4 did not wear her TED hose several times a week. Interview with the PCA on 07/20/21 at 11:00am revealed: -She had assisted Resident #4 with her arm brace this morning. -Resident #4 had her gripper socks on with shoes but did not have on TED hose. -The MAs were responsible for applying and removing the TED hose.	D 367		

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D 367	Continued From page 20 Interview with the SCC on 07/20/21 at 11:10am revealed: -The MAs were responsible for applying and removing the TED hose for Resident #4. -The MAs were also responsible to document on the eMAR if the applied the TED hose or if not place a note under the notes in the eMAR. -There was a specific section on the eMAR labeled "other" if for any reason they could not apply the TED hose for the resident. -Staff should not be documenting they were applying the TED hose if they were not. Interview with the Administrator on 07/20/21 at 11:38am revealed: -She had been the Administrator since 07/14/21. -She was scheduled to be at the facility for the first time on 07/22/21. -She was not familiar with Resident #4. -The process was for the MAs to be responsible for applying and removing the TED hose for the resident. -Her expectation was for the MAs to accurately document the application and removal of the TED hose for the resident. Telephone interview with a second MA on 07/20/21 at 2:00pm revealed: -She had documented she had applied the TED hose on the eMAR when she had not because she had been taught to document she had put them on daily with the exception of when the resident refused. -She was to document the refusal but nothing else. -She knew that was not the correct way to document but that was what she had been trained to do. -She had been trained by another MA.	D 367		

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D 367	Continued From page 21 Attempted interview with the Nurse Practitioner (NP) on 07/20/21 at 2:30pm was unsuccessful.	D 367		
D 461	10A NCAC 13F .1304 Special Care Unit Building Requirements 10A NCAC 13F .1304 Special Care Unit Building Requirements In addition to meeting all applicable building codes and licensure regulations for adult care homes, the special care unit shall meet the following building requirements: (1) Plans for new or renovated construction or conversion of existing building areas shall be submitted to the Construction Section of the Division of Facility Services for review and approval. (2) If the special care unit is a portion of a facility, it shall be separated from the rest of the building by closed doors. (3) Unit exit doors may be locked only if the locking devices meet the requirements outlined in the N.C. State Building Code for special locking devices. (4) Where exit doors are not locked, a system of security monitoring shall be provided. (5) The unit shall be located so that other residents, staff and visitors do not have to routinely pass through the unit to reach other areas of the building. (6) At a minimum the following service and storage areas shall be provided within the special care unit: staff work area, nourishment station for the preparation and provision of snacks, lockable space for medication storage, and storage area for the residents' records. (7) Living and dining space shall be provided	D 461		

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D 461	Continued From page 22 within the unit at a total rate of 30 square feet per resident and may be used as an activity area. (8) Direct access from the facility to a secured outside area shall be provided. (9) A toilet and hand lavatory shall be provided within the unit for every five residents. (10) A tub and shower for bathing of residents shall be provided within the unit. (11) Use of potentially distracting mechanical noises such as loud ice machines, window air conditioners, intercoms and alarm systems shall be minimized or avoided. This Rule is not met as evidenced by: Based on observations, record review, and interviews the facility failed to submit to the Construction Section of the Department of Health and Human Services (DHHS) for review and approval before the conversion of Special Care Unit (SCU) resident room windows which limited opening capacity. The findings are: Observations of window frames in residents' rooms on the SCU on 07/20/21 revealed: -There was a white thick plastic strip located in the bottom of the window frame. -The plastic strip was attached by two screws at each end of the plastic strip to the bottom of the window frame. Interview with Resident #1 on 07/19/21 at 9:37am revealed: -She had left the facility last week by climbing out a window. -She had to leave through the window because	D 461		

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D 461	Continued From page 23 the staff kept the doors locked. Review of progress notes for Resident #1 dated 06/14/21 revealed Resident #1 "continues to exit seek and attempting to take the screens off the windows." Review of progress notes for Resident #1 dated 07/14/21 revealed Resident #4 had eloped from the facility. Interview with the Special Care Coordinator (SCU) Manager on 07/20/21 at 8:41am revealed: -Resident #1 did have an elopement from the facility through a window on 07/14/21. -The Fire Marshall came out to the facility on 07/14/21 at the facility request. -The Fire Marshall indicated they could modify the windows since they had fireproof doors, full sprinklers throughout the facility and the windows could be opened from the outside in the event of a fire. -The Maintenance Director made modifications to all resident rooms on 07/14/21. -He was not aware the Construction Section for the Department of Health and Human Services (DHHS) had to be contacted before the modifications were made to the windows. -He did not call the Construction Section himself nor did he think his Maintenance Director had before the modifications were made. Telephone interview with the Maintenance Director on 07/20/21 at 9:03am revealed: -The Corporate Office Maintenance Supervisor had given them recommendations on modifying the window frames on 07/14/21. -He did not speak to the Fire Marshall on 07/14/21. -He was not aware the Construction Section for	D 461		

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D 461	Continued From page 24 DHHS had to be contacted before the modifications were made to the windows. -He did not call the Construction Section before making the modifications to the windows. Telephone interview with the Administrator on 07/20/21 at 11:38am revealed: -She became the Administrator for the facility on 07/14/21. -She was not aware the Construction Section for DHHS had to be contacted before the modifications were made to the windows.	D 461		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present to meet the needs of the residents in a Special Care Unit (SCU) on the third shift for 4 of 4 third shifts sampled from 07/16/21 to 07/19/21. The findings are: The facility was licensed by the Division of Health Service Regulation as a SCU with a capacity of	D 465		

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D 465	Continued From page 25 60 beds. Review of the facility resident census dated 07/16/21 revealed there was a SCU census of 46 residents, which required 44.8 staff hours on third shift. Review of the individual time sheets dated 07/16/21 revealed 24 staff hours were provided on third shift, leaving the shift short 20.8 hours. Review of the facility resident census dated 07/17/21 revealed there was a SCU census of 46 residents, which required 44.8 staff hours on third shift. Review of the individual time sheets dated 07/17/21 revealed 16 staff hours were provided on third shift, leaving the shift short 28.8 hours. Review of the facility resident census dated 07/18/21 revealed there was a SCU census of 46 residents, which required 44.8 staff hours on third shift. Review of the individual time sheets dated 07/18/21 revealed 24 staff hours were provided on third shift, leaving the shift short 20.8 hours. Review of the facility resident census dated 07/19/21 revealed there was a SCU census of 46 residents, which required 44.8 staff hours on third shift. Review of the individual time sheets dated 07/19/21 revealed 32 staff hours were provided on third shift, leaving the shift short 12.8 hours. Telephone interview with a third shift medication aide (MA) on 07/20/21 at 2:00pm revealed:	D 465		

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D 465	Continued From page 26 -Staff frequently worked short staffed on third shift. -There were only two staff assigned to work third shift over the next six nights. -On the weekend of 07/16/21 there were only two staff working on third shift when there should have been five. -Staff were tired and frustrated with having to care for so many residents and only a couple of people to work. -They did the best they could, but the residents had to wait much longer to receive assistance with their personal care needs. Interview with the Special Care Coordinator (SCC) 07/20/21 at 3:45pm revealed: -The facility did not have enough staff for third shift and there was "no excuse". -One staff had recently been hired but never came in to work. -Two third shift staff had been out on leave. -The corporate office would not allow the facility to employee staff from a local staffing agency. -The facility could not have sister facility staff come in to work on third shift because all facilities were "struggling" with staffing. -It was difficult for two or three staff to care for all the residents in the SCU. -The prior Administrator had just "left" last week and she had been responsible for the staff schedule. -He was responsible for the staff schedule now. -He and the prior Administrator had offered incentives, a third shift differential, and referral bonuses for third shift staff. -He had paid staff from his own money to work extra shifts. Attempted telephone interview with a second third shift MA on 07/20/21 at 3:09pm was	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R 07/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(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 465	Continued From page 27 unsuccessful. Attempted telephone interview with a third third shift MA on 07/20/21 at 3:12pm was unsuccessful. Attempted telephone interview with a fourth third shift MA on 07/20/21 at 3:15pm was unsuccessful.	D 465		
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 observations, interviews and record reviews, the facility failed to ensure residents received care and services relevant to federal and state laws and rules and regulations related to supervision. The findings are: Based on interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) related to two incidents of elopement from the special care unit (SCU) through a window. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].	D912		

Kingsbridge House

Plan of Correction

Annual and Complaint Survey

July 20, 2021

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."

D270--10A NCAC 13F .0901(b) Personal Care and Supervision--page 1

Staff re-training on safety and security of residents with increased visualization and awareness of resident's location. Training included responsibility for immediate notification to the Supervisor in Charge, Memory Care Coordinator and Executive Director when unable to locate a Resident. Training also included responsibilities when a Resident is deemed to be missing, including a thorough search of the inside of the facility, outside grounds and outside areas in the immediate vicinity of the facility. Training completed with the ED, MCC and Lead SIC of their notification requirements to the Responsible Party of the Resident, The Primary Care Provider, the Divisional VP of Operations and/or the Divisional Clinical Director, and in the event the Resident cannot be located, the local Police Department.

The Maintenance Director will complete weekly checks of all windows to ensure egress restriction meets specifications of secured memory care regulations, 6inches.

The Maintenance Director will complete daily door checks to ensure secured system is functioning correctly. Windows will be fitted with a permanent metal fixture to prohibit windows from being opened greater than six-inches and/or removed from track.

Date of Completion—September 3, 2021

D912--G.S. 131D-21(2) Declaration of Residents' Rights—page 28

Retraining has been completed for all staff on Resident Rights related to supervision of Residents to decrease elopement risk. Training included notification responsibilities to Supervisor in Charge, Memory Care Coordinator and Executive Director for Residents exhibiting exit seeking behaviors or verbalization of intent to leave, as well as notification if a Resident is missing. Training also included increased supervision of Residents who are exit seeking and have made previous elopement attempts.

Date of Completion—September 3, 2021

D276—10A 13F .0902 (c)(3-4) Health Care—page 8

An audit of Resident orders will be completed and all ordered medications and treatments will be reviewed for completion. Any findings indicating this has not been implemented or completed will be corrected, and the Physician/Provider will be notified.

Re-training will be completed for the Memory Care Coordinator, Lead Supervisor in Charge and Medication Aides on the importance of Residents receiving all Physician/Provider ordered medications and treatments. Training also included correct documentation and reporting responsibilities when medications or treatment supplies such as TED Hose were not available, or if they were refused by the Resident.

The Memory Care Coordinator will review all new orders weekly, and will do random weekly checks to ensure Residents with TED Hose orders have TED Hose on, and they are being removed as ordered. The Executive Director will complete random audits of completion of scheduled orders and follow up to assist with compliance.

Date of Completion: September 3, 2021

D358 10A NCAC 13F .1104(a) Medication Administration--page 12

All current Medication Aides have been re-trained on the importance of Residents receiving all Physician/Provider ordered medications and treatments in accordance with the Medication Administration Policies and Procedures, including expectations for administration of medications, as well as the process to follow when medications are not available, or if the medications are refused by the Resident. Process will include notification of the Pharmacy, the Executive Director and Memory Care Coordinator (MCC), to determine why the medication is not available and when medication will be delivered, as well as PCP notification for refused medications or treatments. The MCC will notify the PCP to inform of the unavailable medication and receive directions for administration or receive order to hold the medication until delivered by the Pharmacy. Re-training for the MCC, Lead SIC and Medication Aides to also include correct documentation and reporting responsibilities when medications or treatment supplies were not available, or if they were refused by the Resident.

The ED, MCC or designee will complete audits of the medication administration compliance record daily and review each pharmacy delivery for accuracy and delivery of reordered medications. The Executive Director and MCC will complete weekly medication administration compliance reviews to assist with compliance of medication administration. All discrepancies in administration and/or documentation of administration of medications and treatments will be immediately addressed and corrected.

In addition, the Executive Director, MCC, Lead SIC and designated Medication Aides were re-trained on completing a weekly Medication Administration Record review/comparison against the weekly delivery of Multi Dose Packaging (MDP) medications, as well as medications not packaged in MDP. The MCC will process new orders and review the following morning to assure that all medications were received from the pharmacy. In the event any medication is not available for administration, the Med Aides will notify the Pharmacy and the MCC and Lead SIC of the unavailability of the medication. The MCC/Lead SIC will follow up with the Pharmacy to obtain the medication and with the PCP to notify of any missed medications. The MCC/Lead SIC will review the electronic Medication Administration Records (MAR) weekly for accuracy by comparing the MAR against the Physician Orders. Any discrepancies with accuracy of orders will be addressed immediately with both the Pharmacy and the PCP and the MAR will be corrected. An audit of Resident orders will be completed and all ordered medications and treatments will be reviewed for completion. Any findings indicating this has not been implemented or completed will be corrected, and the Physician/Provider will be notified.

Date of Completion: September 3, 2021

D367 10A NCAC 13F 1004(j) Medication Administration--page 17

An audit of Resident orders will be completed and all ordered medications and treatments will be reviewed for completion. Any findings indicating this has not been implemented or completed will be corrected, and the Physician/Provider will be notified. The Executive Director, Memory Care Coordinator and Lead Supervisor in Charge will be retrained on completion of weekly Medication Administration Records audits, checking for accuracy and completeness, as well as appropriate documentation for any omission of medications or treatments with the reason for the omission, including all refused medications or treatments. All Medication Aides will be re-trained on accurate documentation procedures for administration of medications and treatments, as well as documentation for any omission of medications or treatments with the reason for the omission, including all refused medications or treatments.

Date of Completion: September 3, 2021

D461 10A NCAC 13F 1304 Special Care Unit Building Requirements--page 22

Based on the wording and in accordance with rule area 10A 13F 0305(d)(9), "The window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide", the facility did not notify the Construction Division when this measure was put in place, due to the elopement risk of the Residents residing at Kingsbridge House.

Any future design, modifications or construction changes will be submitted to the Construction Division and will not be implemented until approval is obtained.

Date of Completion: September 3, 2021

D465 10A NCAC 13F 1308(a) Special Care Unit Staff—page 25

The Executive Director, Memory Care Coordinator and Lead Supervisor in Charge have been retrained on the staffing ratios and expectations for number of staff required for each shift for adequate coverage. In the event that there is a deficit in staffing to provide and meet the expectations for adequate staff for a shift, and all efforts to staff the facility have been unsuccessful, the Management Team will need to work that shift, and seek guidance from the Divisional VP of Operations and/or the Divisional Clinical Director to assist with finding staff from a sister facility.

Date of Completion: September 3, 2021