| 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 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on March 8-10, 2022. | D 000 | | |
| D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record review the facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) resulting in 5 unwitnessed falls in 3 months.<br><br>The findings are:<br><br>Review of the facility's Falls Management policy revealed:<br>-A falls risk evaluation was completed at the time of move-in.<br>-Falls were recorded in the facility's incident reporting system.<br>-A post fall evaluation was completed after a resident had a fall.<br>-Individualized interventions were considered and the evaluation was a part of the resident record.<br><br>Review of Resident #1's current FL2 dated 06/02/20 revealed:<br>-Diagnoses included artificial left hip joint, dementia, depressive disorder, hypertension, chronic obstructive pulmonary disease, and | D 270 | | |



Reviewed and Acknowledged - SS - 4/25/22

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| D 270 | Continued From page 1<br>anxiety.<br>-Resident #1 was non-ambulatory and intermittently disorientated.<br><br>Review of Resident #1's Care Plan dated 09/06/21 revealed the resident was totally dependent on staff for toileting, ambulation, bathing, dressing, grooming and transferring.<br><br>Review of Resident #1's Licensed Health Professional Support evaluation dated 01/06/22 revealed:<br>-Resident #1's LHPS tasks included ambulation, transferring and oxygen.<br>-Resident #1 was a two-person transfer and used a wheelchair for ambulation.<br><br>Review of Resident #1's falls risk evaluation form dated 09/06/21 revealed:<br>-A resident was considered a "Level 2 fall risk" if there were one or more level 2 question responses with "yes" checked.<br>-Resident #1 was considered a "Level 2" fall risk with a "yes" response checked to the following:<br>-Resident #1 had 9 falls without injury in the past 12 months.<br>-Resident #1 was incontinent and required assistance with toileting.<br>-Resident #1 was identified as having progressive dementia contributing to falls as the resident forgot she could not walk.<br>-Resident #1's lift chair was also listed a factor that may contribute to the residents falls.<br>-Plan included talking to Resident #1's family member about the residents fall risk and alternate placement for higher level of care.<br><br>Interview with Resident #1 on 03/08/22 at 9:00am revealed:<br>-She had "just got back yesterday." | D 270 | | |

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| D 270 | Continued From page 2<br>-She had been out of the facility because of a fractured hip, pointing at her left thigh.<br>-She had memory problems.<br>-She was looking for her bathroom.<br><br>Observation of Resident #1's room on 03/08/22 at 9:10am revealed:<br>-Resident #1 was sitting in a wheelchair.<br>-Resident #1 was using her legs to wheel herself toward the bathroom door.<br><br>Observation of the facility's west hallway on 03/08/22 at 9:24am revealed:<br>-"Help me" could be heard coming from a residents room when exiting another residents room.<br>-Resident #1 was sitting in her wheelchair in her bathroom calling out for "help."<br><br>Interview with Resident #1 on 03/08/22 at 9:24am revealed:<br>-She needed assistance to go to the bathroom.<br>-She had pulled the cord for assistance twice.<br><br>Observation of the pull cord in Resident #1's bathroom on 03/08/22 at 9:24am revealed the help emblem was visible.<br><br>Observation of the pull cord in Resident #1's bedroom on 03/08/22 at 9:27am revealed:<br>-The help emblem was not visible.<br>-The pull cord was pulled, which activated the help emblem.<br>-Resident #1 was calling for help from the bathroom.<br><br>Interview with Resident #1 on 03/02/22 at 9:27am revealed:<br>-Resident #1 asked "Did I do the right thing to not get up by myself." | D 270 | | |

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| D 270 | Continued From page 3<br>-She said she had heard that she was not supposed to get up without assistance.<br><br>Observation of the facility's west hallway on 03/08/22 at 9:30am revealed:<br>-Resident #1 could be heard calling out for help from her bathroom ¾ the way up the hallway.<br>-The medication aide (MA) was at her medication cart around the corner on the adjacent hallway.<br>-Resident #1 could not be heard calling for help on the adjacent hallway.<br><br>Interview with the MA on 03/08/22 at 9:30am revealed when a resident pulled their pull cord her pager was activated.<br><br>Observation of the MA on 03/08/22 at 9:30am revealed:<br>-The MA looked at her pager and responded there were no calls.<br>-She then removed the battery and when she put the battery back in place the pager alarmed to indicate room 31 needed assistance.<br>-She used her walkie talkie to notify the personal care aide (PCA) Resident #1 needed assistance in the bathroom.<br><br>Observation of Resident #1's room on 03/08/22 at 9:34am revealed the Clinical Coordinator arrived at the room to assist Resident #1.<br><br>Observation of Resident #1's hall and room on 03/09/22 at 8:08am revealed:<br>-There was no staff visible in the hallway.<br>-Resident #1 was sitting in her wheelchair, holding a container of a liquid nutritional supplement.<br>-Resident #1 was asleep and her head was tilted downward.<br>-Resident #1 had a brown liquid stain down the | D 270 | | |

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| D 270 | Continued From page 4<br>front of her shirt.<br><br>Observation of Resident #1's hall and room on 03/09/22 at 3:07pm revealed:<br>-Resident #1 was asleep in her lift chair.<br>-Resident #1's call bell was across the room, attached to a stuffed animal which was laying on her bed.<br><br>Interview with Resident #1 on 03/09/22 at 8:45am revealed:<br>-She had fell, more than once, but she did not recall any of the details of her falls.<br>-She did not know why she fell.<br>-She did not stay focused on the conversation related to falls.<br><br>Review of resident #1's incident and accident reports revealed the resident had 16 falls between 04/16/21-12/21/21.<br><br>Review of Resident #1's care conference note dated 10/16/21 at 4:00pm revealed:<br>-Present at the conference was the Health and Wellness Director and two of Resident #1's family members.<br>-Topics discussed included falls with recommendation of a higher level of care and sitters to help with Resident #1's anxiety.<br>-Follow-up needed included family requested palliative care referral. Family was provided list of skilled nursing facilities and the telephone number to the Department of Social Services.<br><br>Review of Resident #1's incident reports and progress notes revealed the resident had 11 falls between 04/16/21-03/07/22; 5 of the falls were between 01/01/22-03/07/22.<br><br>a. Review of Resident #1's progress note dated | D 270 | | |

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| D 270 | Continued From page 5<br><br>01/01/22 at 4:43pm revealed:<br>-Resident #1 was found on the floor with her lift chair all the way up.<br>-Resident #1 was sitting on the floor with her legs crossed.<br>-There was no other documentation on 01/01/22.<br><br>Review of Resident #1's progress notes dated 01/02/22 revealed:<br>-At 5:53am, Resident #1 complained of a headache and was administered Tylenol (used to treat mild pain).<br>-At 6:19am, Resident #1 was assessed for any signs/symptoms (s/s) from the fall and it was documented the resident had none.<br>-Tylenol was effective for treating Resident #1's headache and the resident denied nausea and dizziness.<br>-At 11:00am, Resident #1 had been yelling and tried to hit staff when administering medication.<br>-There was no other documentation on 01/02/22.<br><br>Review of Resident #1's progress notes dated 01/03/22 revealed:<br>-At 2:33am, Resident #1 was resting quietly and aroused easily when spoken to.<br>-Resident #1 was incontinent of urine, incontinence care was provided, and no s/s injury noted from the fall.<br>-At 11:13pm, it was documented fall follow-up, no issues, Resident #1 had a good day.<br><br>Review of Resident #1's progress notes dated 01/04/22 revealed:<br>-At 3:04pm, there was documentation Resident #1 had no complaints and to continue to monitor due to fall.<br>-At 11:12pm, there was documentation fall follow-up, Resident #1 had a good day, no issues. | D 270 | | |

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| D 270 | Continued From page 6<br>There was no documentation of increased supervision to prevent Resident #1 from falling.<br><br>There was no incident report provided for the fall on 01/01/22.<br><br>There was no post fall evaluation completed for the fall on 01/01/22.<br><br>Review of Resident #1's primary care provider's (PCP) visit summary dated 01/04/22 revealed:<br>-Resident #1 was seen for gait instability for a fall on 12/21/21.<br>-There was no documentation related to the fall on 01/01/22.<br>-Clinical note for gait instability was documented as a chronic problem and continue to use wheelchair.<br>-Clinical note for fall was documented as no injuries were sustained, no pain reported and monitor for falls.<br><br>Refer to the interview with a medication aide (MA) on 03/09/22 at 8:15am and 11:37am.<br><br>Refer to the interview to the telephone interview with a second shift MA on 03/09/22 at 8:33pm.<br><br>Refer to the interview to the telephone interview with a third shift MA on 03/10/22 at 3:31am.<br><br>Refer to the interview to the interview with a personal care assistant (PCA) on 03/09/22 at 11:24am.<br><br>Refer to the interview to the interview with the Health and Wellness Director on 03/09/22 at 1:36pm.<br><br>Refer to the interview to the interview with the | D 270 | | |

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| D 270 | Continued From page 7<br>Administrator on 03/09/22 at 4:44pm.<br><br>Refer to the interview with a private duty aide on 03/10/22 at 7:25am.<br><br>Refer to the interview to the telephone interview with the Nurse Practitioner from the ancillary service provider on 03/10/22 at 8:46am.<br><br>Refer to the interview to the telephone interview with Resident #1's family member on 03/10/22 at 9:10am.<br><br>Refer to the interview to the telephone interview with a NP with palliative care services on 03/10/22 at 10:02am and 4:42pm.<br><br>b. Review of Resident #1's progress note dated 01/05/22 at 4:43pm revealed:<br>-At 7:04pm, a late entry was entered, Resident #1 slipped out of her recliner around 1:30pm.<br>-Resident #1 had no marks or bruises and no complaints of pain.<br>-At 9:29pm, there was documentation Resident #1 continued without s/s of injury and had no complaints of pain.<br><br>Review of Resident #1's progress note dated 01/06/22 at 7:06pm revealed Resident #1 had no complaints on 1st and 2nd shift and to continue to monitor due to fall.<br><br>Review of Resident #1's progress note dated 01/07/22 at 6:42am revealed:<br>-Resident #1 was alert and pleasant with confusion.<br>-Resident #1 denied pain.<br>-Status post fall, there were no injuries from fall.<br><br>Review of Resident #1's progress note dated | D 270 | | |

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| D 270 | Continued From page 8<br><br>01/08/22 at 6:38am revealed Resident #1 was alert, pleasant, no complaints of pain, and no signs and symptoms injury from fall.<br><br>There was no documentation of increased supervision to prevent Resident #1 from falling.<br><br>There was no incident report provided for the fall on 01/01/22.<br><br>Refer to the interview with a medication aide (MA) on 03/09/22 at 8:15am and 11:37am.<br><br>Refer to the interview to the telephone interview with a second shift MA on 03/09/22 at 8:33pm.<br><br>Refer to the interview to the telephone interview with a third shift MA on 03/10/22 at 3:31am.<br><br>Refer to the interview to the interview with a personal care assistant (PCA) on 03/09/22 at 11:24am.<br><br>Refer to the interview to the interview with the Health and Wellness Director on 03/09/22 at 1:36pm.<br><br>Refer to the interview to the interview with the Administrator on 03/09/22 at 4:44pm.<br><br>Refer to the interview with a private duty aide on 03/10/22 at 7:25am.<br><br>Refer to the interview to the telephone interview with the Nurse Practitioner from the ancillary service provider on 03/10/22 at 8:46am.<br><br>Refer to the interview to the telephone interview with Resident #1's family member on 03/10/22 at 9:10am. | D 270 | | |

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| D 270 | Continued From page 9<br><br>Refer to the interview to the telephone interview with a NP with palliative care services on 03/10/22 at 10:02am and 4:42pm.<br><br>c. Review of Resident #1's incident report dated 02/04/22 at 6:45pm revealed Resident #1 had an unwitnessed fall without injury.<br><br>Review of Resident #1's progress noted dated 02/04/22 at 11:23pm revealed:<br>-Resident #1 had a fall.<br>-When staff checked on Resident #1, the chair was lifted-up as far as it could go, so assumed the resident slid out of the chair rather than having an actual fall.<br>-The resident was checked for an injury and there were none.<br><br>Review of Resident #1's progress noted dated 02/05/22 at 3:29pm revealed:<br>-Resident #1 was alert with confusion noted which was normal for the resident.<br>- and no signs and symptoms injury from fall.<br><br>Review of Resident #1's progress note dated 02/05/22 at 7:33pm revealed:<br>-Resident #1 slept most of 1st shift.<br>-Continue to monitor due to fall.<br><br>Review of Resident #1's progress note dated 02/06/22 at 1:28am revealed status post fall, no signs or symptoms of injury noted, continue to monitor due to a recent fall.<br><br>Review of Resident #1's progress note dated 02/06/22 at 2:39pm revealed the resident had no complaints and continue to monitor due to a recent fall. | D 270 | | |

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| D 270 | Continued From page 10<br><br>Review of Resident #1's progress note dated 02/06/22 at 11:34pm revealed fall follow-up, Resident #1 was feeling fine and moving around normal without complaint of pain.<br><br>Review of Resident #1's progress note dated 02/07/22 at 1:37am revealed no signs or symptoms of injury noted from fall, and no complaints of pain.<br><br>Review of Resident #1's progress note dated 02/07/22 at 2:40pm revealed no complaints, continue to monitor due to fall follow-up.<br><br>Review of Resident #1's progress note dated 02/08/22 revealed:<br>-At 2:41pm, Resident #1 pulled herself up the hallway twice today, 02/08/22.<br>-Once was to go outside to meet her mother, and the MA positioned Resident #1 by the medication cart to talk.<br>-The second time, Resident #1 wanted to go get the kids, and the personal care aide (PCA) too the resident back to her room, placed her in her recliner and watched tv with the resident.<br>-Resident #1 did not have any complaints of pain or discomfort and to continue to monitor due to recent fall.<br>-At 11:00pm, Resident #1 was administered Lorazepam (used to treat anxiety) due to agitation.<br><br>There was no other documentation of increased supervision to prevent Resident #1 from falling.<br><br>Refer to the interview with a medication aide (MA) on 03/09/22 at 8:15am and 11:37am.<br><br>Refer to the interview to the telephone interview with a second shift MA on 03/09/22 at 8:33pm. | D 270 | | |

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| D 270 | Continued From page 11<br><br>Refer to the interview to the telephone interview with a third shift MA on 03/10/22 at 3:31am.<br><br>Refer to the interview to the interview with a personal care assistant (PCA) on 03/09/22 at 11:24am.<br><br>Refer to the interview to the interview with the Health and Wellness Director on 03/09/22 at 1:36pm.<br><br>Refer to the interview to the interview with the Administrator on 03/09/22 at 4:44pm.<br><br>Refer to the interview with a private duty aide on 03/10/22 at 7:25am.<br><br>Refer to the interview to the telephone interview with the Nurse Practitioner from the ancillary service provider on 03/10/22 at 8:46am.<br><br>Refer to the interview to the telephone interview with Resident #1's family member on 03/10/22 at 9:10am.<br><br>Refer to the interview to the telephone interview with a NP with palliative care services on 03/10/22 at 10:02am and 4:42pm.<br><br>d. Review of Resident #1's progress note dated 02/27/22 revealed:<br>-At 10:41am, there was documentation Resident #1 was found on the floor in front of her chair.<br>-Resident #1 had a small cut on her right arm and aid was given for the cut.<br>-Resident #1 was placed in her chair and the staff "would keep an eye on her."<br>-At 10:37pm, Resident #1 was assisted with toileting, and dressing and transferred to bed with | D 270 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| D 270 | Continued From page 12<br>no signs or symptoms of distress noted.<br><br>Review of Resident #1's progress note dated 02/28/22 revealed:<br>-At 4:15am, there was documentation Resident #1 was resting quietly in bed, aroused easily for incontinence care, dressing to hand dry and intact and no complaints of pain.<br>-9:00pm, there was documentation Resident #1 denied any pain when asked, dressing remained intact, and will continue to monitor.<br><br>Review of Resident #1's progress note dated 03/01/22 revealed Resident #1 ate both meals in the dining room, had no complaints, and to continue to monitor due to a recent fall.<br><br>There was no documentation of increased supervision to prevent Resident #1 from falling.<br><br>There was no incident report provided for the fall on 02/27/22.<br><br>Refer to the interview with a medication aide (MA) on 03/09/22 at 8:15am and 11:37am.<br><br>Refer to the interview to the telephone interview with a second shift MA on 03/09/22 at 8:33pm.<br><br>Refer to the interview to the telephone interview with a third shift MA on 03/10/22 at 3:31am.<br><br>Refer to the interview to the interview with a personal care assistant (PCA) on 03/09/22 at 11:24am.<br><br>Refer to the interview to the interview with the Health and Wellness Director on 03/09/22 at 1:36pm. | D 270 | | |

| 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 270 | Continued From page 13<br><br>Refer to the interview to the interview with the Administrator on 03/09/22 at 4:44pm.<br><br>Refer to the interview with a private duty aide on 03/10/22 at 7:25am.<br><br>Refer to the interview to the telephone interview with the Nurse Practitioner from the ancillary service provider on 03/10/22 at 8:46am.<br><br>Refer to the interview to the telephone interview with Resident #1's family member on 03/10/22 at 9:10am.<br><br>Refer to the interview to the telephone interview with a NP with palliative care services on 03/10/22 at 10:02am and 4:42pm.<br><br>e. Review of Resident #1's incident report dated 03/07/22 at 10:15am revealed:<br>-Resident #1 had an unwitnessed fall with complaint of pain in her left leg.<br>-Resident #1's severity code was documented as #4 for harm and was sent to the hospital for an evaluation.<br><br>Review of Resident #1's progress note dated 03/07/22 revealed:<br>-At 10:24am, there was documentation Resident #1 was observed on the floor by the personal care aide.<br>-Resident #1 complained of neck and left hip pain.<br>-Resident #1 could not extend the left leg without pain.<br>-Resident #1 was sent to the local hospital to be evaluated.<br>-At 9:25pm, Resident #1 returned to the facility.<br>-Resident #1 complained of some pain in the left hip when moving. | D 270 | | |

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| D 270 | Continued From page 14<br>-Staff at the emergency department had reported Resident #1's pelvis and hip x-ray and CT scan of the head were negative.<br><br>Review of Resident #1's post fall evaluation form dated 03/07/22 at 10:47am revealed:<br>-Resident #1's fall was at the residents chair and the chair was all the way up and the residents was on the floor in front of the chair.<br>-Risk factors thought to have contributed to the residents fall included compliance with safety issues and a change in medical/cognitive status.<br>-The form was signed by the Health and Wellness Director on 03/09/22.<br><br>Review of Resident #1's progress note dated 03/08/22 at 6:48am revealed:<br>-Resident #1 was resting quietly in her bed.<br>-Resident #1 continued to be confused.<br>-Resident #1 stated she fell outside, broke her hip, went to the hospital and had surgery.<br>-Staff reoriented Resident #1 that she had a broken hip before, but she did not break her hip when she went to the hospital last night.<br>-Resident #1 stated her hip did not hurt but was getting sore.<br><br>Review of Resident #1's care conference note dated 03/08/22 at 2:30pm revealed:<br>-Present at the conference included the Administrator, the Health and Wellness Director, the Clinical Coordinator, and Resident #1 family member.<br>-Topic discussed was fall management for sitters and status of seeking higher level of care.<br>-Follow up needed included follow-up with Resident #1's family member to see what sitter service he had chosen and when would it be effective and follow-up on skilled nursing placement. | D 270 | | |

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| D 270 | Continued From page 15<br><br>Refer to the interview with a medication aide (MA) on 03/09/22 at 8:15am and 11:37am.<br><br>Refer to the interview to the telephone interview with a second shift MA on 03/09/22 at 8:33pm.<br><br>Refer to the interview to the telephone interview with a third shift MA on 03/10/22 at 3:31am.<br><br>Refer to the interview to the interview with a personal care assistant (PCA) on 03/09/22 at 11:24am.<br><br>Refer to the interview to the interview with the Health and Wellness Director on 03/09/22 at 1:36pm.<br><br>Refer to the interview to the interview with the Administrator on 03/09/22 at 4:44pm.<br><br>Refer to the interview with a private duty aide on 03/10/22 at 7:25am.<br><br>Refer to the interview to the telephone interview with the Nurse Practitioner from the ancillary service provider on 03/10/22 at 8:46am.<br><br>Refer to the interview to the telephone interview with Resident #1's family member on 03/10/22 at 9:10am.<br><br>Refer to the interview to the telephone interview with a NP with palliative care services on 03/10/22 at 10:02am and 4:42pm.<br><br>Interview with a medication aide (MA) on 03/09/22 at 8:15am and 11:37am revealed:<br>-She did not recall Resident #1 receiving physical therapy after falls. | D 270 | | |

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| D 270 | Continued From page 16<br>-Resident #1's lift chair was a problem because Resident #1 would life the chair all the way up and slid down to the floor.<br>-Resident #2 was checked on every 2-hours.<br>-She did not recall any residents being checked on more frequently than every 2-hours.<br>-Resident #1 did not have any type of bed/chair alarm.<br>-Resident #1 had a call bell to use when she needed assistance and the call bell was placed within easy reach.<br>-Resident #1 used to be a one-person transfer but now required two staff for transfers.<br>-Staff were notified of a residents' fall in stand-up (a brief meeting) which was held every day.<br>-Residents were monitored for three days after a fall.<br>-Monitoring depended on why the resident had a fall, like if they fell trying to reach their remote, you would monitor to make sure their remote was within easy reach.<br>-Resident #1 had always been in a room at the end of the hallway.<br>-She thought Resident #1 fell because of her positioning because she would get scooted down toward the footrest of the chair and then when she lifted the chair she slid to the floor.<br>-Resident #1 needed to be watched for her positioning.<br>-Resident #1 was administered medicine often, so she knew the resident was being checked on a lot.<br>-Resident #1 needed a closer eye on her, so she sometimes brought her out to the common area so the resident could watch the birds.<br><br>Telephone interview with a second shift MA on 03/09/22 at 8:33pm revealed:<br>-She was always walking the halls.<br>-Resident #1 had changed since the pandemic. | D 270 | | |

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| D 270 | Continued From page 17<br>-Resident #1 got anxious sitting in her room.<br>-Before the pandemic Resident #1 liked to go outside and now she did not sit up good and did not hold her head up.<br>-Resident #1 liked to sit in her chair and chill.<br>-Resident #1 liked to play with the buttons on the remote to her chair.<br>-Resident #1 would lift the chair right up and slide right down.<br><br>Telephone interview with a third shift MA on 03/10/22 at 3:31am revealed:<br>-After a resident had a fall, she monitored the resident for 3 days.<br>-Monitoring meant checking vitals and making sure the resident did not fall again.<br>-Residents were checked on every 2-hours.<br>-She had never been told to check on Resident #1 more often than every 2-hours.<br>-Resident #1 had not had any falls when she was working.<br>-Resident #1 did get restless.<br>-Resident #1 will yell out for help and when you get to her room, she was looking for her kids.<br>-She will tell Resident #1 she was watching the kids and they are fine.<br>-She will get Resident #1 a snack and or a cup of coffee and she usually settled down.<br>-Resident #1 usually was out of bed by 6:00am.<br>-If Resident #1 was yelling you knew it was time to get her out of bed and get her ready and she then took Resident #1 to the front common area when she worked so Resident #1 would not fall.<br><br>Interview with a personal care assistant (PCA) on 03/09/22 at 11:24am revealed:<br>-She checked on Resident #1 every 2-hours.<br>-After Resident #1 had a fall, se would try to check on her more often, "like every thirty minutes" for her shift. | D 270 | | |

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| D 270 | Continued From page 18<br><br>-She only increased supervision for Resident #1 for the day of the fall.<br>-No one told her to increase supervision for Resident #1, she just did it.<br>-She was told by a MA, Resident #1's falls were because she lifted her motorized chair too high.<br>-She was told by a MA to make sure Resident #1's chair control was not in her chair where the resident could play with it so she would put it in the pocket of the chair.<br>-She tried to make sure Resident #1's call bell was within easy reach, but she might would do better with a pendant around her neck.<br><br>Interview with the Health and Wellness Director on 03/09/22 at 1:36pm revealed:<br>-She had talked to Resident #1's family in October 2021 about sitters for Resident #1 due to falls.<br>-She had also talked to Resident #1's family about the need for a higher level of care.<br>-She also talked to Resident #1's family again after the holidays and again recently.<br>-She was going to provide care conference notes about the meetings.<br>-The MAs were responsible for completing incident reports and post fall evaluations.<br>-Based on the MAs observation of the fall, determined what follow-up was done.<br>-She reviewed the notes to determine what caused the fall and makes referrals if needed.<br>-Examples included if resident might need a urinalysis, or if the call bell needed to be extended.<br>-Each fall was looked at individually.<br>-Resident #1 had "quite a few falls since she had started working at the facility in July 2021."<br>-A lot of Resident #1's falls are related to her lift chair and the remote control to the chair.<br>-Resident #1 will slide onto the floor when she | D 270 | | |

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| D 270 | Continued From page 19<br>uses the remote control because she will lift the chair too high.<br>-A mental health provider had been into see Resident #1 to adjust her medication to decrease Resident #1's anxiety.<br>-Staff have sat with Resident #1 in her room when she was anxious and more confused such as looking for family members who are deceased.<br>-Resident #1 was "all the way down in the end room" so they had brought her up to the common area too.<br>-The staff talked about falls at stand up, what happened and what can we do.<br>-Resident #1's lift chair was beneficial to staff for transfers.<br>-She had talked to Resident #1's family member about the chair being helpful for transfers but also dangerous for the resident.<br>-The remote could not be taken away from Resident #1 because it would take away her ability to get her feet down.<br>-Resident #1 used to sleep in her recliner but would "mess with the remote" and would fall.<br>-Resident #1's fall had improved since she started sleeping in her bed.<br>-She expected staff to put eyes on the residents every 2-4 hours.<br>-There were no residents who were checked on more often than that.<br>-If a resident came back from the hospital, they may check on the resident more frequently.<br>-She had never care planned a resident to be checked on every hour.<br>-They tried to bring Resident #1 up to the receptionist area so she could be watched.<br>-Resident #1 needed to be at a skilled facility for her safety because of so many falls.<br>-She had seen the staff take Resident #1 to the front common area/receptionist, as well as at the medication cart, to be able to keep an eye on her. | D 270 | | |

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| D 270 | Continued From page 20<br>-The only thing she could think of that they could have done to try to prevent Resident #1 from falling was to have required sitters sooner.<br><br>Interview with the Administrator on 03/09/22 at 4:44pm revealed:<br>-She was the Campus Director and oversaw this facility and the Memory Care Facility next door.<br>-Between the two facilities she had four nurses, one registered nurse (RN) who was the Health and Wellness Director and the Clinical Care Coordinator was a licensed practical nurse (LPN) at this facility.<br>-She was aware of Resident #1's falls.<br>-Recommendations had been given to the family, but the family was pushing back.<br>-At a meeting with Resident #1's family on 03/08/22, the family was told they were going to issue a 30-day discharge notice because the facility could no longer meet Resident #1's needs, and the family responded that they thought the care the resident was receiving was just fine.<br>-Staff participated in stand-up meetings daily and falls were discussed.<br>-Resident who had falls had alert charting to remind the MAs to monitor the resident.<br>-Monitoring the resident meant to pay attention to see how the resident was feeling, or to monitor if something else was going on.<br>-After a fall, the resident was discussed at stand up for two weeks.<br>-Things that were implemented to try to prevent falls was to bring Resident #1 to the common area where they could keep a closer eye on the resident.<br>-An ancillary care service was initiated in January 2021 for the Nurse Practitioner (NP) who would evaluate for additional services for Resident #1.<br>-They looked at the 7 layers of behavior for every fall, such as what could cause the falls, such as | D 270 | | |

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| D 270 | Continued From page 21<br><br>medications, what triggered, who was working, was the chair close by, and so forth but these discussions were not documented.<br>-She had said to the MAs and PCAs before to check on Resident #1 more frequently.<br>-Resident #1 really needed sitters and that was discussed with the family on 03/08/22.<br>-A different type of chair had not been recommended for Resident #1 because the resident could not manage a different chair and that would be considered a restraint.<br>-The facility did not use bed or chair alarms.<br><br>Interview with a private duty aide on 03/10/22 at 7:25am revealed:<br>-She was hired to work with Resident #1 from 9:00pm-9:00am.<br>-Resident #1 tried to get out of her bed at 12:00am, 1:00am, and 3:00am.<br>-She reassured Resident #1 everything was okay, and she was not alone.<br>-Resident # was then okay.<br><br>Telephone interview with the Nurse Practitioner from the ancillary service provider on 03/10/22 at 8:46am revealed:<br>-She saw Resident #1 on a monthly basis.<br>-When she first saw Resident #1 in January 2022, her focus was on talking to Resident #1's family member about the need for long term care for Resident #1 to get more assistance because the resident was dependent on oxygen, needed to be transferred from bed to chair, needed more redirection and was having falls.<br>-She was aware Resident #1 had a fall on 03/07/22 and was sent to the emergency department.<br>-Resident #1 had another fall that she did not know about until she arrived at the facility.<br>-She was not surprised Resident #1 had falls | D 270 | | |

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| D 270 | Continued From page 22<br>because the resident needed assistance but thought she could do things for herself.<br>-Resident #1 needed to be in an area where staff could keep an eye on her.<br>-If Resident #1 was in a long-term care facility there would be more staff available to keep an eye on the resident.<br>-Resident #1 was more likely to have a fall if she was in the room by herself.<br>-If Resident #1 was having falls on 2-hour checks staff should increase their frequency or maybe move to a room closer to the front of the facility.<br>-In an ideal work Resident #1 would benefit from checks every hour, but even then, there was no guarantee the resident would not fall.<br>-In a nursing home (long term care facility) a resident would have eyes on them at all times, but in an assisted living, "not too much."<br>-She thought bed and chair alarms were a good idea in long term care facility, but she did not know the policy of assisted living facilities and the use of the alarms.<br>-She had not thought about physical therapy for Resident #1 because on her second visit to see Resident #1 the resident was complaining of a headache, so she was more focused on the medical needs at the time.<br>-Physical therapy was good for strengthening but with a resident with dementia she did not know how much benefit therapy would be.<br>-A physical therapy consult would be good to determine what type of chair would be safer for Resident #1.<br>-She planned to see Resident #1 today, 03/10/22.<br><br>Telephone interview with Resident #1's family member on 03/10/22 at 9:10am revealed:<br>-Resident #1 had "quite a few falls."<br>-Resident #1 had a fall recently that he did not know about until he was at the facility for a visit | D 270 | | |

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| D 270 | Continued From page 23<br>and noticed a bloody bandage on Resident #1's arm.<br>-He thought some of Resident #1's falls were because she got confused about the buttons on her lift chair.<br>-Resident #1 would push the wrong button, lift her chair too high and slide to the floor.<br>-Resident #1 was complaining of hip pain after her fall on 03/07/22, but everything checked out fine.<br>-Resident #1 thought she could walk, but could not, and when got up on her own, she would fall.<br>-He thought the primary reason Resident #1 fell was because of her confusion.<br>-He did not know how often the staff checked on Resident #1.<br>-He thought that since the facility had less residents on the hall where Resident #1 was located, that maybe the staff did not go down the hall as much since most of the other residents were independent.<br>-He did not know if this was true, but he had thought about it.<br>-Moving Resident #1 to a room closer to the front of the facility was cost prohibited.<br>-He was currently working on a long-term care facility for Resident #1.<br><br>Telephone interview with a NP with palliative care services on 03/10/22 at 10:02am and 4:42pm revealed:<br>-She had only seen Resident #1 a couple of times.<br>-She was aware of some of Resident #1's falls, but maybe not all of the falls.<br>-She was told the staff had increased supervision for Resident #1.<br>-Resident #1 told her she was not supposed to do anything by herself.<br>-Her focus for Resident #1 had been on | D 270 | | |

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| | HAL001024 | A. BUILDING: _____ B. WING _____ | 03/10/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BROOKDALE BURLINGTON AL (NC) | 3615 SOUTH MEBANE STREET BURLINGTON, NC 27215 |

| (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 |
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| D 270 | Continued From page 24<br>placement.<br>-She saw Resident #1 on 02/16/22 and she was told Resident #1 had not had any recent falls.<br>-She thought Resident #1 would benefit from increased supervision, checking on more often.<br>-She thought staff should be providing anticipatory care as well.<br>-Anticipatory care was anticipating needs such as bathroom breaks and having things within reach "anticipating what the resident might need."<br>-She was not aware Resident #1 had 5 falls since 01/01/22 and if she had she would have recommended a physical therapy consult. | D 270 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure notification and follow-up for 1 of 5 sampled residents (#5) related to the resident's refusal to wear TED hose.<br><br>The findings are:<br><br>Review of Resident #5's current FL-2 dated 10/26/21 revealed diagnoses included diabetic ketoacidosis, COVID-19, and clostridium-difficile.<br><br>Review of Resident #5's physician orders revealed there was an order dated 11/17/21 for bilateral TED hose apply on resident in the morning and remove in the evening. | D 273 | | |

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| D 273 | Continued From page 25<br><br>Review of Resident #5's January 2022 electronic medication administration (eMAR) revealed:<br>-There was an entry for TED hose apply to bilateral legs in the morning for edema and remove per schedule, scheduled to apply at 6:00am and remove at 8:00pm.<br>-There was documentation of application and removal of the TED hose from 01/01/22 to 01/11/22, 01/16/22, and from 01/21/22 to 01/22/22 at 6:00am and 8:00pm.<br>-There was documentation of removal and no documentation of application of the TED hose on 01/12/22, 01/15/22, 01/19/22 at 8:00pm<br>-There was documentation of application of the TED hose and no documentation of removal on 01/17/22, 01/18/22, and 01/23/22 at 6:00am.<br>-There was documentation of refusal or other/see notes from 01/12/22 to 01/15/22, from 01/17/22 to 01/20/22, and from 01/23/22 to 01/31/22.<br><br>Review of Resident #5's January 2022 progress notes revealed:<br>-There was a note dated 01/12/22 at 6:12 am and 01/13/22 at 5:18am that Resident #5's TED hose were lost.<br>-There were notes dated 01/13/22 at 7:47pm, 01/14/22 at 8:09pm, 01/17/22 at 7:32pm, 01/23/22 at 8:02pm, 01/24/22 at 8:38pm, 01/25/22 at 8:12pm, 01/26/22 at 8:00pm, 01/27/22 at 7:18pm, 01/28/22 at 8:19pm, 01/29/22 at 8:34pm, 01/30/22 at 8:26pm, and 01/31/22 at 10:29pm that Resident #5 was not wearing TED hose.<br>-There was a note dated 01/14/22 at 5:08am, 01/20/22 at 5:28am that Resident #5 was missing one TED hose.<br>-There was a note dated 01/15/22 at 5:52am that there was one TED hose lost.<br>-There was a note dated 01/18/22 at 7:37pm that Resident #5 did not wear her TED hose because | D 273 | | |

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| D 273 | Continued From page 26<br>the hose were dirty.<br>-There was a note dated 01/19/22 at 5:16am that the MA was awaiting a new pair of TED hose to be delivered.<br>-There was a note dated 01/20/22 at 8:11pm that Resident #5 could not fit into the TED hose.<br>-There was a note dated 01/24/22 at 5:28am that Resident #5 had a small open wound on her right foot and did not want to wear the TED hose.<br>-There was a note dated 01/25/22 at 6:09am that Resident #5 planned to wear the TED hose after her bath.<br>-There was a note dated 01/26/22 at 6:30am that Resident #5 refused to wear the TED hose because she wanted to sleep.<br>-There was a note dated 01/27/22 at 5:40am that Resident #5 refused to wear the TED hose because it was too early to apply the TED hose.<br>-There was a note dated 01/28/22 at 6:15am that Resident #5 refused to wear the TED hose because it was too early to apply the TED hose.<br>-There were notes dated 01/29/22 at 6:31am, 01/30/22 at 6:25am, and 01/31/22 at 5:48am that Resident #5 refused to wear the TED hose.<br><br>Review of Resident #5"s February 2022 eMAR revealed<br>-There was an entry for TED hose apply to bilateral legs in the morning for edema and remove per schedule, scheduled to apply at 6:00am and remove at 8:00pm.<br>-There was documentation of application and removal of the TED hose from 02/06/22 to 02/07/22, from 02/15/22 to 02/16/22, and 02/18/22 at 6:00am and 8:00pm.<br>-There was documentation of removal and no documentation of application of the TED hose from 02/04/22 to 02/05/22, from 02/08/22 to 02/11/22, 02/14/22, 02/21/22, and 02/24/22 at 8:00pm | D 273 | | |

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| D 273 | Continued From page 27<br>-There was documentation of application of the TED hose and no documentation of removal on 02/17/22, 02/19/22, and 02/20/22 at 6:00am.<br>-There was documentation of refusal or other/see notes from 02/01/22 to 02/05/22, from 02/08/22 to 02/14/22, 02/17/22, and from 02/19/22 to 02/28/22.<br><br>Review of Resident #5's February 2022 progress notes revealed:<br>-There were notes dated 02/01/22 at 6:18am, 02/02/22 at 5:16am, 02/03/22 at 5:16am, 02/11/22 at 6:51am, 02/12/22 at 6:41am, 02/14/22 at 6:33am, 02/22/22 at 6:28am, 02/26/22 at 5:31am, and 02/28/22 at 6:20am that Resident #5 refused to wear TED hose.<br>-There was a note dated 02/01/22 at 8:36pm, 02/03/22 at 7:36pm, 02/12/22 at 8:44pm, 02/13/22 at 8:39pm, 02/17/22 at 8:30pm, 02/22/22 at 8:48pm, 02/23/22 at 7:56pm, 02/25/22 at 7:41pm, 02/26/22 at 8:43pm, 02/27/22 at 8:48pm that Resident #5 was not wearing TED hose.<br>-There was a note dated 02/02/22 at 8:55pm that Resident #5 reported removing her TED hose herself.<br>-There was a note dated 02/04/22 at 6:37am, 02/05/22 at 6:38am, 02/23/22 at 6:20am, and 02/27/22 at 7:08am without any documentation.<br>-There was a note dated 02/08/22 at 6:48am that Resident #5 would apply her TED hose when she awakened.<br>-There was a note dated 02/09/22 at 6:40am that Resident #5 would apply her TED hose after her bath.<br>-There was a note dated 02/13/22 at 6:42am that Resident #5 would apply her TED hose later.<br>-There was a note dated 02/18/22 at 12:35am that Resident #5 stated it was too early to apply the TED hose. | D 273 | | |

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| D 273 | Continued From page 28<br><br>Review of Resident #5's March 2022 eMAR revealed<br>-There was an entry for TED hose apply to bilateral legs in the morning for edema and remove per schedule, scheduled to apply at 6:00am and remove at 8:00pm.<br>-There was documentation of application and removal of the TED hose on 03/04/22 at 6:00am and 8:00pm.<br>-There was documentation of removal and no documentation of application of the TED hose on 03/07/22, and 03/08/22 at 8:00pm<br>-There was documentation of refusal or other/see notes from 03/01/22 to 03/03/22, and from 03/05/22 to 03/09/22.<br><br>Review of Resident #5's March 2022 progress notes revealed:<br>-There was a note dated 03/03/22 at 7:45pm that Resident #5 was not wearing TED hose.<br>-There was a note dated 03/05/22 at 6:53am without any documentation.<br><br>Observation of Resident #5 on 03/08/22 at 5:20pm revealed she was not wearing any TED hose or any socks.<br><br>Observation of Resident #5 on 03/09/22 at 8:05am revealed she was not wearing any TED hose.<br><br>Interview with Resident #5 on 03/10/22 at 10:18am revealed:<br>-She did not wear TED hose because she did not need them.<br>-Her legs were swollen when she was admitted to the facility in 11/2021, but now her legs were no longer swollen.<br>-She liked her physician and she thought they | D 273 | | |

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| D 273 | Continued From page 29<br><br>had good discussions about her health.<br>-Her physician examined her legs each time she had a visit from her, but she did not tell her she was no longer wearing the TED hose.<br><br>Telephone interview with a representative at Resident #5's physician's office on 03/09/22 at 3:52pm revealed there were no notifications to the physician concerning Resident #5 refusal to wear her TED hose.<br><br>Interview with a medication aide (MA) on 03/09/22 at 11:03am revealed:<br>-Resident #5 refused to wear her TED hose.<br>-When a resident refused a physician ordered treatment repeatedly, she told her supervisor the Health and Wellness Director (HWD).<br>-She had told the HWD about Resident #5's refusal to wear her TED hose.<br>-She did not document the notification to her supervisor, but she did document the resident's refusals.<br><br>Interview with the HWD on 03/10/22 at 12:10pm revealed:<br>-When a resident was repeatedly refusing a physician ordered treatment, she completed a physician notification form and faxed it to the physician, or she discussed the refusals when the physician visited the facility weekly.<br>-She did not always document when she notified the physician about refusals in the progress notes, but the physician notification forms were placed in residents' records.<br>-She did not know Resident #5 had refused to wear her TED hose so often from January 2022 to March 2022.<br>-Staff had not told her Resident #5 refused to wear her TED hose.<br>-She had not discussed Resident #5's refusal to | D 273 | | |

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| D 273 | Continued From page 30<br>wear her TED hose with the physician<br>-If she was aware, she would have discussed it with Resident #5's physician.<br>-She was responsible for ensuring the physician was notified when a resident refused an ordered treatment.<br><br>Interview with the Administrator on 03/10/22 at 1:19pm revealed:<br>-She expected the MAs and the HWD to report repeated refusals to the physician.<br>-The HWD was responsible for ensuring the physician was notified for resident refusals.<br><br>Attempted interview with Resident #5's physician on 03/09/22 at 3:53pm was unsuccessful. | D 273 | | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders<br>(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:<br>(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;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to clarify medication | D 344 | | |

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| D 344 | Continued From page 31<br><br>orders for 1 of 5 sampled residents (Resident #1) related to a medication used to treat nightmares.<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 06/02/20 revealed diagnoses included artificial left hip joint, dementia, depressive disorder, hypertension, chronic obstructive pulmonary disease, and anxiety.<br><br>Review of Resident #1's physician order dated 10/14/21 revealed:<br>-There was an order for Prazosin 2mg (used to treat nightmares) at bedtime for thirty days.<br>-There were 3 refills on the medication.<br><br>Review of Resident #1's December 2021 electronic medication administration record (eMAR) revealed:<br>-There was an entry for Prazosin 2mg with a scheduled administration time of 8:00am.<br>-Prazosin 2mg was documented as administered at 8:00am from 12/01/21-12/11/21.<br>-There was no documentation as to why Prazosin was not administered from 12/12/21-12/31/21.<br><br>Review of Resident #1's pharmacy review dated 02/14/22 revealed:<br>-Resident #1's Prazosin order was for 2mg at bedtime for 30 days with 3 refills was stopped after 30 days.<br>-Please clarify with Resident #1's primary care provider (PCP) if Prazosin 2mg should continue/restart.<br><br>Review of Resident #1's January 2022, February 2022, and March 2022 eMARs revealed Prazosin was not listed as a current medication. | D 344 | | |

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| D 344 | Continued From page 32<br><br>Review of Resident #1's medications on hand on 03/09/22 at 4:24pm revealed Prazosin was not on the medication cart.<br><br>Telephone interview with the Pharmacist at the facility's contract pharmacy on 03/09/22 at 8:30am revealed:<br>-Prazosin 2mg with directions to administer one tablet at bedtime was dispensed on 10/14/21 for 28 tablets.<br>-There was no order to discontinue Prazosin 2mg.<br>-Twenty-eight tablets of Prazosin 2mg were dispensed on 01/03/22, 01/31/22, and 02/28/22.<br>-It appeared one of the dispensing had been returned to the pharmacy, but he was not familiar with the codes as to why the medication was returned.<br><br>Interview with a medication aide (MA) on 03/09/22 at<br>-Resident #1's Prazosin had been discontinued because it was for a limited number of days.<br>-She did not see the refills on the physician's order.<br>-She had been sending the Prazosin back to the pharmacy because she thought there was no current order for the medication.<br>-If she had seen the refills on the medication, she would have contacted the pharmacy or Resident #1's PCP for clarification.<br><br>Review of the pharmacy return medication bin on 03/10/22 at 3:17pm revealed Resident #1's punch card for 28 tablets of Prazosin 2mg with a dispense date of 03/07/22.<br><br>Telephone interview with Resident #1's PCP's medical assistant on 03/09/22 at 3:26pm revealed: | D 344 | | |

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| D 344 | Continued From page 33<br>-Resident #1's PCP was not available.<br>-Prazosin was listed as a current medication in the resident's medical record.<br>-Prazosin was prescribed for nightmares.<br><br>Interview with the Health and Wellness Director (HWD) on 03/08/22 at 4:33pm revealed:<br>-The order for Resident #1's Prazosin should have been clarified.<br>-The MA was responsible for receiving and processing medications when they were delivered to the facility.<br>-When Resident #1's Prazosin was sent to the facility the MA should have contacted the pharmacy to see why the medication had been sent for clarification.<br><br>Interview with the HWD on 03/10/22 at 12:08pm revealed:<br>-The pharmacy reviews were sent to her by the pharmacist.<br>-She overlooked the pharmacist's recommendation to have Resident #1 Prazosin clarified.<br><br>Interview with the Administrator on 03/08/22 at 4:44pm revealed:<br>-She was not aware Resident #1had not received Prazosin as ordered.<br>-She expected one of the facility's nurses to have caught the order and had it clarified.<br>-She also would have expected the pharmacy to have caught the discrepancy during their pharmacy reviews. | D 344 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration | D 358 | | |

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| D 358 | Continued From page 34<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents(#3 and #5) related to missed doses of a medication used to treat insomnia (#3) and missed doses of a medication used to treat elevated blood glucose levels (#5).<br><br>The findings are:<br><br>1. Review of Resident #3's current FL-2 dated 12/09/21 revealed:<br>-Diagnoses included acute kidney failure, vascular dementia, type 2 diabetes mellitus, and chronic pain syndrome.<br>-There was an order for Trazodone 50mg at bedtime.<br><br>Review of Resident #3's December 2021 electronic medication administration record (eMAR) revealed:<br>-There was an entry for trazodone 50mg at bedtime, scheduled for 8:00pm.<br>-There was documentation that Resident #3 was in the local hospital or absent from the facility from 12/01/21 to 12/16/21.<br>-There was documentation of administration of trazodone 50mg on 12/20/21, 12/25/21, and from 12/28/21 to 12/31/21 at 8:00pm. | D 358 | | |

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| D 358 | Continued From page 35<br>-There was documentation of other/see notes and hold/see notes from 12/17/21 to 12/19/21, 12/21/21, 12/24/21, and 12/27/21.<br>-There was documentation of "pharmacy action required" on 12/18/21, from 12/22/21 to 12/23/21, and 12/26/21.<br><br>Review of Resident #3's December 2021 progress notes revealed:<br>-Resident #3 returned to the facility from a skilled nursing facility on 12/17/21.<br>-On 12/17/21 at 4:58pm, there was a note that the orders were entered for trazodone 50mg one tablet at bedtime.<br>-On 12/17/21 at 9:16pm, 12/18/21 at 9:06pm, 12/23/21 at 8:23pm, 12/24/21 at 8:34pm and 12/27/21 at 8:51pm, there were notes that trazodone 50mg was "on order".<br>-On 12/19/21 at 8:15pm, there was a note with documentation of "awaiting pharmacy delivery" for trazodone 50mg.<br>-On 12/20/21 at 7:45am, there was a note with documentation of "medication has not arrived from pharmacy".<br>-On 12/21/21 at 8:16pm and 12/22/21 at 8:48pm, there were notes with documentation of "waiting on delivery" for trazodone 50mg.<br>-On 12/26/21 at 8:42pm, there was an entry without any documentation.<br><br>Observation of Resident #3's medications in the facility on 03/09/22 at 10:30am revealed there was one bubble package containing 26 tablets of trazodone 50mg that were dispensed on 03/07/22.<br><br>Telephone interview with a representative at Resident #3's facility contracted pharmacy on 03/10/22 at 8:00am revealed:<br>-The facility was on a cycle fill for refilling oral | D 358 | | |

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|---|---|---|---|
| | HAL001024 | A. BUILDING: _____ B. WING _____ | 03/10/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE BURLINGTON AL (NC) | 3615 SOUTH MEBANE STREET BURLINGTON, NC 27215 |

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| D 358 | Continued From page 36<br>medications every 28 days.<br>-Resident #3 had 28 tablets of trazodone dispensed on 12/06/21, 01/03/22, 01/21/22, and 02/28/22.<br>-The pharmacy did not have a FL-2 dated 12/09/21 for Resident #3.<br>-If a resident left the home and was admitted to another facility, the facility sent the resident's medications back to the pharmacy.<br>-He did not know if Resident #3's medications dispensed on 12/06/21 were sent back to the pharmacy.<br><br>Interview with Resident #3 on 03/10/22 at 10:07am revealed:<br>-When she came back to the facility, she received some of her medications.<br>-She noticed that the pill cup contained fewer pills than her usual number of pills.<br>-She could not determine which medications were missing from the pill cup.<br>-She told her physician that she had difficulty sleeping when she returned to the facility.<br>-She thought that she did not have anything prescribed to help her sleep.<br><br>Interview with a medication aide (MA) on 03/09/22 at 11:03am revealed:<br>-She recalled that there was difficulty obtaining Resident #3's medications when she returned from a skilled nursing facility.<br>-She thought the pharmacy did not send Resident #3's medications because of an insurance issue.<br>-She did not remember if Resident #3 returned to the facility with medications.<br>-When refills were needed for a resident, she clicked a button on the eMAR to reorder the medication.<br>-If she ordered a medication in the morning , it was delivered during the night shift. | D 358 | | |

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| D 358 | Continued From page 37<br>-If she had difficulty obtaining a medication, she told the Health and Wellness Director (HWD).<br>-She thought Resident #3 had some of her medication and some were missing.<br>-She did not know the specific medication that were missing for Resident #3.<br><br>Interview with the HWD on 03/10/22 at 12:10pm revealed:<br>-She thought Resident #3 did not return to the facility from the SNF with medications.<br>-When residents were admitted to the facility, the MAs entered the medication orders into the eMAR system and the pharmacy received the orders.<br>-Another MA was supposed to verify the medication orders in the eMAR system.<br>-She did not review the physician orders and compare them with the eMAR to ensure orders were entered accurately.<br>-MAs were supposed to request refills prior to using all of the medication.<br>-MAs could request a refill by calling or faxing the pharmacy or request a refill using the eMAR system.<br>-She did not know Resident #3 did not have Trazodone for 10 days in December 2021.<br>-She expected the MAs to request refills of medication from the pharmacy.<br>-If there was any difficulty in obtaining the medication, the MA was expected to notify her.<br><br>Interview with the Administrator on 03/10/22 at 1:19pm revealed<br>-She did not know Resident #3 went without trazodone for 10 days in December 2021.<br>-She expected the MAs to refill medications and notify the HWD if there were any difficulties in obtaining medications. | D 358 | | |

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| D 358 | Continued From page 38<br><br>Attempted telephone interview with Resident #3's physician on 03/09/22 at 3:53pm was unsuccessful.<br><br>2. Review of Resident #5's current FL-2 dated 10/26/21 revealed:<br>-Diagnoses included diabetic ketoacidosis, COVID-19, and clostridium-difficile.<br>-There was a medication order for insulin NPH 20 units twice daily as needed for blood sugar over 140.<br><br>Review of Resident #5's physician orders revealed:<br>-There was an order dated 11/11/21 for Novolin N 100units/ml per sliding scale.<br>-There was an order dated 11/16/21 to discontinue NPH insulin.<br>-There was an order dated 12/10/21 for Novolog insulin per sliding scale (SSI) as follows: blood sugar 0-150= 0 units, 151-200=3 units, 201-250= 6 units, 251-300= 9 units, 301-350=12 units, 351-400= 15 units, 401-450= 18 units, and more than 450 call the physician.<br>-There were instructions to administer the SSI after Resident #5's blood glucose was checked.<br><br>Review of Resident #5's January 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for Novolog insulin per SSI blood sugar 0-150= 0 units, 151-200=3 units, 201-250= 6 units, 251-300= 9 units, 301-350=12 units, 351-400= 15 units, 401-450= 18 units, and more than 450 call the physician, scheduled for 7:00am, 11:00am, 5:00pm, and 8:00pm.<br>-There was documentation of administration of insulin based on the blood sugar level from 01/01/22 to 01/08/22, from 01/10/22 to 01/20/22, and from 01/24/22 to 01/31/22 at 7:00am, | D 358 | | |

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| D 358 | Continued From page 39<br><br>11:00am, 5:00pm, and 8:00pm.<br>-There was documentation of administration of insulin based on the blood sugar level on 01/09/22 at 7:00am, 5:00pm, and 8:00pm.<br>-There was documentation of administration of insulin based on the blood sugar level on 01/21/22 and 01/22/22 at 7:00am.<br>-There was documentation of administration of insulin based on the blood sugar level on 01/23/22 at 7:00am, 11:00am and 8:00pm.<br>-There was documentation of other/see notes and awaiting pharmacy delivery on 01/09/22 at 11:00am, 01/21/22 and 01/22/22 at 11:00am, 5:00pm, and 8:00pm and 01/23/22 at 5:00pm.<br>-There were 8 doses of SSI not administered when Resident #5's blood sugar ranged from 170 to 287.<br><br>Review of Resident #5's January 2022 progress notes revealed:<br>-There was a note dated 01/09/22 at 10:18am that Resident #5 did not have any insulin.<br>-The MA documented "pharmacy sending some in backup".<br>-There was a note dated 01/21/22 at 10:44am that Resident #5 was "out of insulin".<br>-There were notes dated 01/21/22 at 4:42pm and 8:39pm that staff were awaiting a delivery from pharmacy.<br>-There were notes dated 01/22/22 at 11:52am, 5:02pm, and 8:12pm without any documentation.<br>-There was a note dated 01/23/22 at 4:44pm without any documentation.<br><br>Review of Resident #5's February 2022 eMAR revealed:<br>-There was an entry for Novolog insulin per SSI blood sugar 0-150= 0 units, 151-200=3 units, 201-250= 6 units, 251-300= 9 units, 301-350=12 units, 351-400= 15 units, 401-450= 18 units, and | D 358 | | |

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| D 358 | Continued From page 40<br><br>more than 450 call the physician, scheduled for 7:00am, 11:00am, 5:00pm, and 8:00pm.<br>-There was documentation of administration of insulin based on the blood sugar level from 02/01/22 to 02/08/22, from 02/10/22 to 02/18/22, from 02/20/22 to 02/24/22, and from 02/26/22 to 02/28/22 at 7:00am, 11:00am, 5:00pm, and 8:00pm.<br>-There was documentation of other/see notes on 02/09/22 at 11:00am.<br>-There was no documentation of the amount of SSI administered to Resident #5 on 02/19/22 and 02/25/22 at 11:00am.<br>-There were 3 doses of SSI not administered when Resident #5's blood sugar ranged from 197 to 229.<br><br>Review of Resident #5's February 2022 progress notes revealed:<br>-There was a note dated 02/09/22 at 10:18am that Resident #5 did not have any insulin to administer.<br>-There were no notes for 02/19/22 and 02/25/22 concerning Resident #5's blood sugar or insulin.<br><br>Observation of Resident #5's medications on hand in the facility on 03/09/22 at 10:40am revealed:<br>-There was a opened pen of Novolog insulin without a documented open date on the medication cart.<br>-There were two unopened pens of Novolog insulin in the medication refrigerator<br><br>Interview with Resident #5 on 03/08/22 at 10:17am revealed:<br>-She received insulin and felt better than she felt when living independently.<br>-She did not know how much insulin she received each time. | D 358 | | |

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| D 358 | Continued From page 41<br><br>Telephone interview with a representative at the facility contracted pharmacy on 03/10/22 at 9:48am revealed:<br>-Resident #5 had an order for Novolog sliding scale insulin blood sugar 0-150= 0 units, 151-200=3 units, 201-250= 6 units, 251-300= 9 units, 301-350=12 units, 351-400= 15 units, 401-450= 18 units, and more than 450 call the physician, scheduled for 7:00am, 11:00am, 5:00pm, and 8:00pm.<br>-Two pens of Novolog insulin were dispensed on 02/09/22 and 03/08/22.<br>-One pen of Novolog insulin was dispensed on 12/10/21, 12/11/22, 01/09/22, and 01/22/22.<br>-He did not know the length of time each pen would last for Resident #5 because it was administered on a sliding scale.<br><br>Interview with a medication aide (MA) on 03/09/22 at 11:03am revealed:<br>-She completed refills for residents' medications on the eMAR system.<br>-She notified the HWD if a medication was not delivered the following day or the next time she worked.<br>-She did not recall a time when Resident #5 did not have insulin available for administration.<br>-She ordered Resident #5's insulin when she had two insulin pens in the refrigerator.<br><br>Interview with the Health and Wellness Director (HWD) on 03/10/22 at 12:10pm revealed:<br>-She expected the MAs to reorder insulin for residents when there was one pen remaining in the refrigerator.<br>-She was not aware that Resident #5 had missed 11 dose of sliding scale insulin in January 2022 and February 2022.<br>-She expected the MAs to call the backup | D 358 | | |

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| D 358 | Continued From page 42<br><br>pharmacy when there was a medication that was needed immediately.<br>-The MAs were responsible for refills and notifying her if there was difficulty with obtaining a medication.<br><br>Interview with the Administrator on 03/10/22 at 1:19pm revealed:<br>-She was not aware that Resident #5 did not received 11 doses of sliding scale insulin in January 2022 and February 2022.<br>-The MAs and HWD were responsible for ensuring medications were administered as ordered by the PCP<br><br>Attempted telephone interview with Resident #5's PCP on 03/09/22 at 3:53pm was unsuccessful. | D 358 | | |
| D 367 | 10A NCAC 13F .1004(j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(8) name or initials of the person administering | D 367 | | |

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| D 367 | Continued From page 43<br>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).<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of medication administration records for 2 of 5 sampled residents related to a nutritional supplement and an anti-anxiety medication (#1) and a medication used to treat nerve pain (#2) .<br><br>The findings are:<br><br>1. Review of Resident #1's current FL2 dated 06/02/20 revealed diagnoses included artificial left hip joint, dementia, depressive disorder, hypertension, chronic obstructive pulmonary disease, and anxiety.<br><br>a. Review of Resident #1's signed physicians orders dated 01/11/22 revealed an order for Lorazepam 0.5mg/ml gel apply to the skin topically every 6 hours as needed for agitation.<br><br>Review of Resident #1's January 2022, February 2022, and March 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for Lorazepam 0.5mg/ml gel apply to the skin topically every 6 hours as needed for agitation.<br>-There was documentation Lorazepam was administered on 01/08/22, 01/27/22, 02/08/22, and 02/18/22.<br>-There were 4 doses documented as administered.<br><br>Review of Resident #1's controlled substance count sheets (CSCS) revealed: | D 367 | | |

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| D 367 | Continued From page 44<br><br>-There was a CSCS for Lorazepam 0.5mg/ml gel apply to skin topically every 6 hours as needed for agitation.<br>-There was documentation Resident #1 was administered Lorazepam on 01/02/22, 01/08/22, 01/27/22, 01/30/22, 02/02/22, 02/08/22, and 02/18/22.<br>-There were 7 doses documented as administered.<br><br>Observation of Resident #1's medication on hand on 03/08/22 at 4:32pm revealed:<br>-There were 4 prefilled syringes in a pharmacy labeled package.<br>-There were 15 prefilled syringes with a dispense date of 12/03/21.<br>-The number of syringes on hand was accurate with the CSCS but did not match the documentation on Resident #1's eMARs.<br><br>Telephone interview with a medication aide (MA) on 03/09/22 at 8:39pm revealed:<br>-When she administered medication, she used the eMAR to make sure there was a current order and the medication on the cart was the correct medication.<br>-Controlled medication was documented in the eMAR and on the CSCS.<br>-She acknowledged administering Resident #1's Lorazepam syringe on 02/02/22.<br>-She did not know why she did not document administering Resident #1's Lorazepam in the eMAR, "it was just a mistake."<br>-She did not know why she did not use the eMAR other than she was just in a hurry.<br><br>Interview with a MA on 03/10/22 at 9:43am revealed:<br>-When she administered controlled medication, she pulled up the medication in the eMAR to | D 367 | | |

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| D 367 | Continued From page 45<br>make sure the medication was current, administer the medication and documented on the eMAR, and completed a chart note why she administered the medication and completed the CSCS.<br>-She acknowledged that she administered Resident #1's Lorazepam syringes on 01/02/22 and 01/30/22.<br>-If the Lorazepam was not recorded on the January 2022 eMAR, it was because she just forgot to put it in the eMAR.<br><br>Interview with the Health and Wellness Director (HWD) on 03/09/22 at 5:21pm revealed:<br>-When a MA administered controlled medication, she expected the MA to use the eMAR like any other medication, making sure it was the right resident and right medication, administer the medication, and document in the eMAR as well as the CSCS.<br>-She and the Clinical Nurse Coordinator completed eMAR audits.<br>-She reviewed the CSCS to make sure there were no discrepancies.<br>-She had not compared the eMAR to the CSCS.<br>-She expected the MA to document the administration of the medication on the resident's eMAR as well as document the effectiveness of the prn medication administered.<br>-She was not aware Resident #1 had Lorazepam administered that was documented on the CSCS but was not documented on the resident's eMAR.<br><br>Interview with the Administrator on 03/09/22 at 4:44pm revealed:<br>-The HWD and the Clinical Nurse Coordinator both audited the eMARs.<br>-The resident's CSCS should match up with the resident's eMAR.<br>-The MAs were supposed to use the eMAR for | D 367 | | |

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| D 367 | Continued From page 46<br>medication administration and then complete the CSCS as well.<br><br>b. Review of Resident #1's signed physicians orders dated 01/11/22 revealed an order for Cranberry 450mg daily (a nutritional supplement).<br><br>Review of Resident #1's January 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for Cranberry 450mg daily with a scheduled administration time of 10:00am.<br>-There was documentation Cranberry 450mg was administered from 01/01/22-01/31/22.<br><br>Review of Resident #1's February 2022 eMAR revealed:<br>-There was an entry for Cranberry 450mg daily with a scheduled administration time of 10:00am.<br>-There was documentation Cranberry 450mg was administered from 02/01/22-02/28/22.<br><br>Review of Resident #1's March 2022 eMAR revealed:<br>-There was an entry for Cranberry 450mg daily with a scheduled administration time of 10:00am.<br>-There was documentation Cranberry 450mg was administered from 03/01/22-03/08/22.<br><br>Review of a clarification order from the pharmacy dated 01/12/22 revealed:<br>-The clarification order below was being faxed to allow you to update Resident #1's eMAR to reflect what was being dispensed from the pharmacy.<br>-The change was made due to the original strength/dosage not being available from the pharmacy.<br>-New order dispensed as Cranberry 425mg take one capsule once daily. | D 367 | | |

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|---|---|---|---|
| | HAL001024 | A. BUILDING: _____ B. WING _____ | 03/10/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE BURLINGTON AL (NC) | 3615 SOUTH MEBANE STREET BURLINGTON, NC 27215 |

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| D 367 | Continued From page 47<br><br>Telephone interview with the Pharmacist at the facility's contracted pharmacy revealed:<br>-Resident #1's original physician's order was for Cranberry 450mg, however that strength was not available, so it was changed to 425mg.<br>-A physician's order was not required for a change in strength for OTC supplements in most cases, and Cranberry was one of those that did not require a new order.<br>-The facility was notified of the change and was expected to update the eMAR on their end.<br><br>Interview with the MA on 03/10/22 at 10:20am revealed:<br>-When she administered medications, she checked to make sure it was the right resident, the right medication, and the right time.<br>-If there was a discrepancy in the milligrams for the medication she would check immediately before administering the medication.<br>-She had not noticed the discrepancy between Resident #1's Cranberry order on the eMAR and the pharmacy's dispensing label.<br>-She did not see the notification from the pharmacy related to the Cranberry changes that needed to be made on the eMAR.<br>-If she had noticed the discrepancy, she would have contacted the pharmacy for clarification.<br><br>Interview with the Health and Wellness Director (HWD) on 03/10/22 at 9:22am revealed:<br>-The MAs were responsible for checking medications in when the medications were delivered to the facility.<br>-The MAs would compare medications delivered to ensure there was a matching order.<br>-She was not aware Resident #1's Cranberry strength did not match the order that was on the eMAR.<br>-She expected the MAs to make sure the | D 367 | | |

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| D 367 | Continued From page 48<br>medications delivered matched the orders in the eMAR system.<br>-If the medication delivered did not match the order, she would expect the MA to get clarification on the issue by calling the pharmacy or the PCP and to communicate the discrepancy with her.<br><br>Interview with the Administrator on 03/10/22 at 12:15pm revealed if Resident #1's eMAR and medication on hand were not the same, she would have expected the MA to tell the HWD or to contact the pharmacy for clarification.<br><br>2. Review of Resident #2's current FL-2 dated 02/10/22 revealed:<br>-Diagnoses included hypertension, insomnia, and polyneuropathy.<br>-There was an order for Pregabalin 100mg (used to treat pain), take one capsule at bedtime.<br><br>Review of Resident #2's signed physician's order dated 02/15/22 revealed an order for Pregabalin 100mg twice per day as needed for pain.<br><br>Review of Resident #2's February 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for Pregabalin 100mg once daily with a scheduled administration time of 8:00pm.<br>-There was documentation Pregabalin 100mg was administered from 02/01/22-02/28/22 at 8:00pm.<br><br>Review of Resident #1's March 2022 eMAR revealed:<br>-There was an entry Pregabalin 100mg once daily with a scheduled administration time of 8:00pm.<br>-There was documentation Pregabalin 100mg was administered from 03/01/22-03/08/22 at | D 367 | | |

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| D 367 | Continued From page 49<br>8:00pm.<br><br>Observation of Resident #2's medication on hand on 03/09/22 at 3:10pm revealed:<br>-There was a punch card for Pregabalin 100mg, take one capsule twice a day as needed for pain.<br>-The Pregabalin was dispensed on 02/16/22 for 28 capsules, there were 8 capsules remaining in the punch card.<br><br>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/10/22 at 12:27pm revealed:<br>-Resident #2 had two orders for Pregabalin, one was for administration daily at bedtime, and the other was for prn (as needed) for pain.<br>-The last time Resident #2's Pregabalin to be administered at bedtime was dispensed was 11/08/21 for 28 tablets.<br>-The MAs must have been using the prn Pregabalin package to administer Resident #1's medication.<br><br>Interview with Resident #2 on 03/10/22 at 7:58am revealed:<br>-He took Pregabalin at bedtime.<br>-He did not know the current order for Pregabalin, but the medication made him sleepy and he only took it at bedtime.<br><br>Interview with the medication aide (MA) on 03/10/22 at 10:20am revealed:<br>-She had noticed Resident #2's punch card for Pregabalin had the directions as needed, but Resident #2 only wanted the medication at bedtime because it made him too sleepy and it was changed to bedtime.<br>-When the Pregabalin punch card was dispensed she did not contact the pharmacy because Resident #2 needed the medication at bedtime | D 367 | | |

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| D 367 | Continued From page 50<br>and it would have taken more time to get another punch card delivered to the facility so she administered the medication from the punch card provided.<br>-She had mentioned the discrepancy to the Health and Wellness Director (HWD) and the HWD said she would look into it.<br>-She also called the pharmacy to see if there was a new order and the pharmacy was supposed to fax over the new order, but she had not checked back with the pharmacy. (She did not recall when she had contacted the pharmacy).<br>-It had "slipped her mind" to follow up on the order for the Pregabalin, but she did tell Resident #2 he might have to ask for the medication at bedtime since the directions on the punch card was as needed.<br><br>Interview with the HWD on 03/10/22 at 9:22am revealed:<br>-The MAs were responsible for checking medications in when the medications were delivered to the facility.<br>-The MAs would compare medications delivered to ensure there was a matching order.<br>-She was not aware Resident #2's Pregabalin punch card did not match the order that was on the eMAR.<br>-She expected the MAs to make sure the medications delivered matched the orders in the eMAR system.<br>-If the medication delivered did not match the order, she would expect the MA to get clarification on the issue by calling the pharmacy or the PCP and to communicate the discrepancy with her.<br><br>Interview with the Administrator on 03/10/22 at 12:15pm revealed if Resident #1's eMAR and medication on hand were not the same, she would have expected the MA to tell the HWD or to | D 367 | | |

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| D 367 | Continued From page 51<br>contact the pharmacy for clarification. | D 367 | | |
| D 612 | 10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp)<br><br>10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM<br>(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to 41 residents during the global coronavirus (COVID-19) pandemic as related to the screening of residents.<br><br>The findings are:<br><br>Review of the facility's COVID-19 policies revealed:<br>-There was a COVID-19 "playbook" that was last | D 612 | | |

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| D 612 | Continued From page 52<br>updated on 12/22/21.<br>-On page 4 of the booklet, there was guidance to use a screening log for visitors and staff.<br>-On page 11 of the booklet under the heading of "COVID-19 Positive Cases in Community", there was guidance to screen all residents daily using a screening log and to document on progress notes for residents who tested positive for COVID-19 or presumed positive for COVID-19<br>-On page 20 of the booklet under the heading of "Cohorting Residents", there was guidance to screen all residents daily using a screening log.<br>-On page 30 of the booklet under the heading of "Setting Up a Special Isolation Unit", there was guidance to screen all residents daily using a screening log.<br>-There was a separate COVID-19 Screening Log Policy dated 10/2021 with guidance that staff would complete the COVID-19 screening process with residents, healthcare providers, visitors for entry into the facility.<br><br>Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARs-CoV-2 spread in Nursing Homes dated 02/22/22 revealed residents should be evaluated daily for symptoms of COVID-19 and actively monitor residents for fever.<br><br>Review of the North Carolina Department of Health and Human Services COVID-19 Post Acute Care Setting Infection Control Assessment and Response (ICAR) tool dated 10/2021 revealed staff and residents should be actively screened daily for fever, signs and symptoms of COVID-19.<br><br>Review of five residents' January 2022, February 2022, and March 2022 electronic medication administration records (eMARs) revealed there | D 612 | | |

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| D 612 | Continued From page 53<br>was no documentation of any temperatures.<br>Interview with a resident on 03/09/22 at 10:32am revealed:<br>-The facility staff "used to take" her temperature daily.<br>-It had been so long she did not recall when her temperature was last checked.<br>-If her temperature had been checked recently, she would have remembered.<br><br>Interview with another resident on 03/09/22 at 10:39am revealed she had COVID-19 in February 2022 and the medication aides (MA) checked her temperature every shift but had not checked it since she recovered (she was sick about 10 days).<br><br>Interview with another resident on 03/09/22 at 10:41am revealed:<br>-It had been so long since her temperature was checked that she did not recall the date.<br>-She could tell when she had a temperature, and she had not had one.<br><br>Interview with two residents on 03/09/22 at 10:54am revealed:<br>-When they first moved into the facility the staff checked their temperatures a lot.<br>-The staff had not checked their temperature in "quite some time."<br>-The primary care provider (PCP) checked their temperatures during her visits.<br>Interview on 03/09/22 with a resident residing on the assisted Living (AL) hall at 11:05am revealed:<br>-Staff did not take her temperature to check for symptoms of illness.<br>-No one offered to check her temperature.<br>-Staff checked her pulse daily.<br>-She did not know why staff did not offer to check her temperature. | D 612 | | |

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| D 612 | Continued From page 54<br><br>Interview on 03/09/22 with a second resident, residing on the AL hall, at 11:10am revealed:<br>-Staff took her temperature last week while she was sick.<br>-Staff did not check her temperature until she became sick.<br>-If she was concerned about checking her temperature she had to walk to the lobby and check her own temperature using the screening thermometer used for visitors and staff.<br><br>Interview on 03/09/22 with a third resident, residing on the AL hall, at 11:15am revealed:<br>-She had not been asked to have her temperature at any time.<br>-She had her temperature checked when she went to her medical appointments.<br><br>Interview on 03/09/22 with a fourth resident, residing on the AL hall, at 11:17am revealed:<br>-She was never asked if staff could check her temperature for signs of illness.<br>-The nurse at her primary care provider (PCP) always checked her temperature during appointments.<br><br>Interview on 03/09/22 with a fifth resident, residing on the AL hall, at 11:35am revealed:<br>-Staff did not ask to make temperature checks to residents<br>-She had not had her temperature checked in a long time; she did not remember when her temperature had been checked.<br>-She would like to know her temperature reading.<br>-She would feel more confident in knowing if she was not becoming ill.<br><br>Interview on 03/10/22 with a sixth resident, residing on the AL hall, at 11:23am revealed: | D 612 | | |

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| D 612 | Continued From page 55<br>-Staff checked his temperature sometimes, not routinely.<br>-Staff checked his temperature today because he did not feel well.<br><br>Interview with a medication aide (MA) on 03/09/22 at 11:03am revealed:<br>-The residents' temperatures were not being taken daily because there were currently no residents who had tested positive for COVID-19.<br>-The residents' temperatures were taken daily only during the COVID-19 outbreaks at the facility.<br>-Staff had standup meetings and during the meetings was when updates were provided to staff.<br>-Resident's temperatures were no longer checked but she could not remember when the MAs stopped checking residents' temperatures.<br><br>Interview with another MA on 03/09/22 at 8:05pm revealed:<br>-She did not take the residents' temperatures daily, but she did not know when she stopped.<br>-She took residents' temperatures if they complained of not feeling well.<br>-There was a thermometer for use at the facility.<br>-Previously, she obtained resident temperatures daily and documented the resident's temperatures in a booklet.<br>-Once the facility was COVID-19 free, the daily temperature checks stopped.<br>-Each time there was a COVID-19 outbreak the temperatures of residents who tested positive were taken frequently.<br><br>Interview with the Health and Wellness Director (HWD) on 03/10/22 at 12:10pm revealed:<br>-Residents were screened for COVID-19 during the beginning of the pandemic. | D 612 | | |

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| D 612 | Continued From page 56<br>-Visitors and staff were screened for COVID-19.<br>-Staff reported when a resident did not feel well or had a fever.<br>-Residents' temperatures were obtained frequently during COVID-19 outbreaks within the facility.<br>-Resident temperatures were obtained for residents who tested positive.<br>-Daily resident temperature screening was discontinued, but she did not recall the exact date.<br><br>Interview with the Administrator on 03/10/22 at 1:19pm revealed:<br>-Visitors and staff were still screened and their temperatures were checked.<br>-She received guidance concerning COVID-19 from the facility's corporate meetings.<br>-She did not know the CDC guidelines indicated daily monitoring for fever and signs and symptoms of COVID-19.<br>-She knew residents' temperatures were no longer obtained daily.<br>-She was responsible for ensuring the CDC guidelines were followed concerning daily resident screening. | D 612 | | |

The following is the Plan of Correction for Brookdale Burlington Assisted Living regarding the Statement of Deficiencies dated 3/31/2022. This Plan of Correction is not to be construed as an admission of or agreement services and will continue to make changes and improvement to satisfy that objective with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care.

D 270- Personal Care and Supervision

The ED/HWD or designee will conduct an in-service on falls management policy with staff to include Incident report, post falls investigation, and progress notes that are to be completed. HWD/designee will follow up on incidents on a daily basis and ensure policy is being followed.

To be completed by 4-30-22

D 358- Medication Administration

The ED/HWD or designee will in-service all medication aids on the 6 rights of medication administration, to include follow up documentation on the MAR and in the residents record, to be completed by. The ED/HWD or designee will conduct periodic MAR/Flow sheet audits at a minimum of twice weekly to ensure proper follow up documentation for treatments and orders.

To be completed by 5-30-22

D- 273 Health Care

The ED/HWD or designee will have in-service on follow-up with physician for medication refusals with staff. HWD/ designee will conduct periodic MAR audits at a minimum of twice a week to ensure proper follow up documentation for medication refusals.

To be completed by 5-30-22

D 344- Medication orders

The ED/HWD/ or designee will have in-service on follow up with physician for verification or clarification of orders for medications and treatments with staff. HWD/designee will conduct periodic MAR audits at a minimum of twice a week to ensure proper follow up on communication documentation with physicians.

To be completed by 5-30-22

D- 367 Medication Administration

The ED/ HWD or designee will provide an in-service on Medication administration documentation. HWD/designee will conduct periodic MAR audits to Narcotic book at a minimum of twice a week to ensure proper medication administration documentation is performed.

To be completed by 5-30-22