

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL076007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/04/2021
NAME OF PROVIDER OR SUPPLIER BROOKDALE ASHEBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 514 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on November 3-4, 2021.	D 000		
D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a care plan was developed for 2 of 5 sampled residents (Residents #3 and #5) within 30 days following admission. 1. Review of Resident #3's current FL2 dated 04/12/21 revealed: -Diagnoses included Alzheimer's Disease, type II diabetes, and hypertension. -She was intermittently disoriented. -She required personal care assistance with bathing and dressing. -She was continent of bladder and bowel. Review of Resident #3's Resident Register revealed she was admitted on 04/16/21. Review of Resident #3's care plan dated 06/30/21 revealed: -Resident #3 was evaluated by a Registered Nurse (RN). -The care plan was not signed by a Physician.	D 259	Resident care plans will be completed within thirty (30) days following admission. Care plans will be completed by the Health & Wellness Director or designee, and reviewed and signed by a Physician.	12/31/2021 ongoing

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Executive Director

12/11/2021

STATE FORM

6899

PD6H11

If continuation sheet 1 of 10

Resident care plan signed by J. L. Chen
12/17/21

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D 259	Continued From page 1 -Resident #3 had insulin-dependent diabetes and required blood sugar monitoring and insulin injections. -She was independent with eating, ambulation, dressing, grooming, and bathing. Review of Resident #3's record revealed there was no documented care plan completed prior to 06/30/21. Interview with a personal care aide (PCA) on 11/04/21 at 11:20am revealed: -All residents had a resident profile in the care plan binder that listed the resident's needs. -She received report from the previous shift PCA or the medication aide (MA) regarding any changes to a resident's care needs. -Resident #3 was very independent and had never asked her for assistance with personal care. Interview with a MA on 11/03/21 at 11:35am revealed: -Resident #3 had diabetes and required assistance with finger stick blood sugars (FSBS) and insulin injections. -Resident #3 was independent with personal care needs. Refer to the interview with the Special Care Unit Coordinator (SCC) on 11/04/21 at 2:20pm. Refer to the interview with the Administrator on 11/04/21 at 10:30am. Refer to the interview with the Regional Registered Nurses on 11/04/21 at 2:30pm. 2. Review of Resident #5's current FL2 dated 09/14/21 revealed:	D 259		

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D 259	Continued From page 2 -Diagnoses included vascular dementia, dysphagia and conversion disorder with seizures. -The recommended level of care was a Special Care Unit (SCU). -He was incontinent of bladder and bowel. -He was ambulatory with assistance of a walker. Review of Resident #5's Resident Register revealed he was admitted to the SCU on 09/20/21. Review of Resident #5's initial care plan dated 09/17/21 revealed: -The care plan was not signed by a Physician or the facility's Registered Nurse (RN). -The care plan did not state who evaluated Resident #5. -Resident #5 required total assistance with dressing. -Resident #5 required as needed physical assistance with grooming. -Resident #5 required as needed physical assistance with bathing his lower body and verbal prompting with bathing his upper body. -Resident #5 required physical assistance with toileting. -Resident #5 was independent with eating. -Resident #5 required physical assistance and verbal prompting with ambulation while using a mobility aid. Interview with a personal care aide (PCA) in the Special Care Unit (SCU) on 11/04/21 at 10:05am and 12:45pm revealed: -All the residents in the SCU had a resident profile in the care plan binder that outlined what they required assistance with. -The PCAs were supposed to initial on a resident's task list when they assisted a resident. -Resident #5 required assistance with dressing,	D 259		

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D 259	Continued From page 3 bathing and grooming. -She provided assistance on as needed basis for toileting and feeding. -Resident #5 required supervision when he used his walker and had to be pushed in his wheelchair. Attempted review of Resident #5's task list on 11/04/21 10:15am was unsuccessful due to the task list could not be located. Interview with a medication aide (MA) on 11/04/21 at 10:15am revealed Resident #5 was very unsteady when he tried to walk and required a walker or wheelchair. Refer to the interview with the Special Care Unit Coordinator (SCC) on 11/04/21 at 2:20pm. Refer to the interview with the Administrator on 11/04/21 at 10:30am. Refer to the interview with the Regional Registered Nurses on 11/04/21 at 2:30pm. Interview with the Special Care Unit Coordinator (SCC) on 11/04/21 at 2:20pm revealed: -The care plan was used to generate a task list for the resident's needs for each shift. -Care plan assessments were completed by the Regional Registered Nurse (RN) or a different RN that was shared with the facility's sister community. -The care plan was usually completed prior to the resident's admission and another care plan was completed within 30 days after admission. -She did not know who was responsible for ensuring that the care plans were signed by a physician.	D 259			

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D 259	Continued From page 4 Interview on 11/04/21 at 10:30am with the Administrator revealed: -The facility did not currently have a health and wellness director. -The care plans were behind because the facility did not currently have a Health and Wellness director (HWD). -Due to staffing shortages all staff are having to spend more time with direct patient care over paperwork, and he must have missed some of the Care Plan documentation which prompted the nurses to complete the paperwork. -The Regional nurses were currently providing coverage at the facility for Care Plans. -He was ultimately responsible to assure all Care plans are completed for the residents; however, he had to spend more time providing resident care, and the documentation had fallen behind. Interview on 11/04/21 at 2:30pm with the Regional Nurses revealed: -They had been assisting at the facility in the absence of a Health and Wellness Nurse. -They had been doing the Care Plans at the facility. -When they came to the facility there was a system in place that prompted them of which care plans needed completed. -One of them tried to come to the facility weekly to make sure all paperwork that was needed was completed. -They did not know why there were some care plans that had not been completed.	D 259		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support	D 278	Licensed Health Professional Support (LHPS) assessments will be completed for identified tasks for residents by the Health and Wellness Director, or designee, accordingly for each resident with identified tasks.	11/5/2021 Ongoing

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D 278	Continued From page 5 (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established);	D 278			

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D 278	Continued From page 6 (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) assessment	D 278		

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D 278	Continued From page 7 was completed on 2 of 5 sampled residents for identified tasks of finger stick blood sugars (FSBS) and insulin injections (Resident #3) and physical assistance with ambulation while using a mobility aide (Resident #5). The findings are: 1. Review of Resident #3's current FL2 dated 04/12/21 revealed: -Diagnoses included diabetes type II. -There was an order for Novolin insulin 70/30 (a medication used to lower blood sugar levels), 12 units at breakfast and dinner. -There was an order for Novolog insulin (a medication used to lower blood sugar levels), 4 units with lunch. Review of Resident #3's Primary Care Provider's (PCP) orders dated 10/21/21 revealed: -The Novolin 70/30 insulin was discontinued. -She was to receive Lantus insulin (a medication used to lower blood sugar levels), 14 units, every morning at 9:00am. -She was to receive Novolog insulin, 6 units, before lunch and supper. -She was to have her FSBS checked before meals and at bedtime. Interview with the medication aide (MA) on 11/03/21 at 10:40am revealed Resident #3 was to have her FSBS checked before lunch and would receive an insulin injection unless the reading was less than 150. Observation on 11/03/21 at 11:35am revealed the MA checked Resident #3's FSBS and administered insulin to Resident #3. Review of Resident #3's medical record revealed	D 278		

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D 278	Continued From page 8 there was no licensed health professional support (LHPS) evaluation. Refer to the interview with the Administrator on 11/04/21 at 10:30am. Refer to the interview with the Regional Registered Nurses on 11/04/21 at 2:30pm. 2. Review of Resident #5's current FL2 dated 09/14/21 revealed: -Diagnoses included vascular dementia, dysphagia and conversion disorder with seizures. -He was constantly disoriented and ambulatory with assistance of a walker. Review of Resident #5's current care plan dated 09/17/21 revealed: -Resident #5 required physical assistance and verbal prompting with ambulation while using a mobility aid. -Resident #5 used a walker and wheelchair. -Resident #5 had fallen in the last 12 months. Interview with a personal care aide (PCA) on 11/04/21 at 10:05am revealed Resident #5 required supervision when he used his walker and had to be pushed in his wheelchair. Review of Resident #5's record revealed there was not a licensed health professional support (LHPS) evaluation. Refer to the interview with the Administrator on 11/04/21 at 10:30am. Refer to the interview with the Regional Registered Nurses on 11/04/21 at 2:30pm. Interview on 11/04/21 at 10:30am with the	D 278		

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D 278	Continued From page 9 Administrator revealed: -The facility did not currently have a health and wellness director. -The licensed health professional support (LHPS) were behind because the facility did not currently have a Health and Wellness director (HWD). -Due to staffing shortages all staff had to spend more time with direct patient care over paperwork, and he must have missed some of the LHPS documentation which prompted the nurses to complete the paperwork. -The Regional nurses were currently providing coverage at the facility for LHPS. -He was ultimately responsible to assure all LHPS are completed for the residents; however, he had to spend more time providing resident care, and the documentation had fallen behind. Interview on 11/04/21 at 2:30pm with the Regional Nurses revealed: -They had been assisting at the facility in the absence of a Health and Wellness Nurse. -They had been doing the LHPS at the facility. -When they came to the facility there was a system in place that prompted them of which LHPS needed completed. -One of them tried to come to the facility weekly to make sure all paperwork that was needed was completed. -They did not know why there were some LHPS not completed.	D 278			