Division of Health Service Regulation

Received via email 05/06/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076034	A. BUILDING: _____ B. WING _____	R-C 04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE HAVEN	501 POINTE SOUTH DRIVE RANDLEMAN, NC 27317

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 04/06/22 through 04/08/22, with an exit via telephone on 04/08/22.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure health care follow up for 1 of 5 sampled residents (Resident #5) who had an order to remove staples from his skin. The findings are: Review of Resident #5's current FL2 dated 03/03/22 revealed: -Diagnoses included active autistic disorder, schizoaffective disorder and bipolar, and intellectual and developmental disability. -Personal care needs included bathing, feeding and dressing. Review of Resident #5's incident and accident report dated 03/14/22 revealed: -Resident #5 fell in his room and hit his head resulting in a bleeding wound requiring transfer to the emergency room (ER). -Resident #5 returned from the ER with staples in his head (did not specify how many). -There were new orders for Motrin to help relieve pain, and to remove the staples in 7 days.	{D 273}	Administrator/Designee retrained staff on noticing change in conditions with residents and the procedures of notifying responsible parties and management staff of changes in resident conditions. SIC/Designee will notify responsible parties and primary care provider of any changes in care, condition, and/or services to residents. SIC/Designee will review new orders daily to ensure each order is referred to and appropriate agency if indicated. RCC and/or Designee to audit all orders once per week x 4 weeks, then once per month ongoing to assure any orders needing to be referred to outside agencies or providers are completed	5/23/2022 5/23/2022 5/23/2022 5/23/2022

Acknowledged and Accepted 05/06/22 KHH

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{D 273}	Continued From page 1 Review of Resident #5's ER discharge summary dated 03/14/22 revealed: -Resident #5 had been evaluated for accidental fall and scalp laceration. -There was a note documenting the laceration had been repaired with staples in the ER and to have the staples removed in 7 days (03/22/22). -Resident #5's primary care provider (PCP) had initialed and dated the discharge summary on 03/17/22. Observation of Resident #5 on 04/07/22 at 9:10am revealed: -There was one staple intact to the top of his head over a healed area of skin and a light pink scar. Interview with a medication aide (MA) on 04/07/22 at 2:55pm revealed: -She had completed the incident and accident report from 03/14/22 and had sent Resident #5 to the ER for evaluation of his scalp laceration. -She had not completed the area on the incident and accident report that documented he had returned with new orders to have his stapled removed in 7 days. -She thought he had two staples in his head when he had returned from the ER but was not sure. -Resident #5 preferred to do his own bathing so she had not completed a skin assessment on him since he had fallen. -The personal care aides (PCA) did skin checks on residents weekly and were supposed to report any skin concerns to the MAs to follow up on. -She was unaware that Resident #5 still had one staple in his scalp. Telephone interview with a MA on 04/07/22 at 3:00pm revealed: -Resident #5 did not allow staff to bathe him or	{D 273}		

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complete full skin assessments on him.
-Resident #5 had not made any complaints about his head hurting or itching.

Interview with Resident #5 on 04/07/22 at 3:33pm revealed:
-He had accidentally removed some staples to his head with his comb, he did not know how long ago.
-He did not know how many staples they had repaired his laceration with.
-His head did not hurt and was not itchy or bothersome to him.
-Nobody had looked at his head or assessed his wound since the staples had initially been placed in the ER.

Interview with the Resident Care Coordinator (RCC) on 04/07/22 at 4:00pm revealed:
-Resident #5 had been transferred to the ER on 03/14/22 due to a bleeding wound from his head after he fell in his room.
-He returned from the ER with at least 5 staples in his head.
-Resident #5 had pulled some of the staples out with his comb a few days after they had been placed.
-Resident #5's PCP was aware that he had pulled some of the staples out and advised that they replace the staples with steri-strips.
-The facility did not have steri-strips available to use so they updated the PCP and received no further orders.
-Resident #5's PCP had last been to the facility a week prior, but she did not know if she had evaluated Resident #5 or not during that visit.
-She was not aware that Resident #5 still had a staple in his scalp.

Telephone interview with the Executive Director

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{D 273}	Continued From page 3 (ED) on 04/08/22 at 11:30am revealed: -She had completed Resident #5's incident and accident report from his fall on 03/14/22 and noted that he returned with orders to remove his staples in 7 days. -She had provided a copy of Resident #5's ER discharge summary to his PCP for review. -Resident #5's PCP told her that she would remove his staples at her next visit. -She was not aware that Resident #5 still had a staple in his scalp. -Skin checks were done on all residents weekly by the PCAs and nobody had reported to her that Resident #5 still had a staple in his scalp. -Resident #5 had not mentioned to staff that he still had a staple in his scalp and he had not made any complaints of pain to that area. -It was the responsibility of the RCC to make sure all orders were implemented. Attempted interview with Resident #5's PCP on 04/07/22 at 3:15pm was not successful.	{D 273}		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.	D 287		

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D 287	Continued From page 4 This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure all residents were provided non-disposable place settings at meal service. The findings are: Observation of the breakfast meal of a non-ambulatory resident on 04/06/22 at 12:40 am revealed: -The resident's meal was served to her in the room. -The resident received feeding assistance from staff to consume the meal. -There was a bedside table near the resident. -On the bedside table was a disposable bowl with an unidentifiable pureed substance and there was a plastic spoon in the bowl. -The resident had a nutrition shake in a disposable cup and a plastic spoon in the cup. -Written on the outside of the cup was the resident's name, date (04/06/22) and time (8:00am). -There was a second cup with what appeared to tea in a disposable cup. -There was a personal care aide (PCA) attempting to feed the resident. Interview with the PCA on 04/06/22 at 12:42pm revealed: -The resident's meal was always put in a disposable plate ware because she ate in her room. -If the resident did not consume the meal, then the staff attempting to feed the resident should take unused food items out of the room. Observation on 04/06/22 at 12:50pm of a second resident who received her meal in her room	D 287	Dietary staff will place non-disposable setting including knife, fork, spoon, plate and beverage container, unless individual exception has been made and documented as per 10A NCAC 13F .0904(2) Dietary manager will monitor meals x 5 days per week to ensure all residents receive place settings in accordance to 10A NCAC 13F .0904(b)(2) Administrator will monitor meals randomly to ensure all residents receive a place setting in accordance to 10A NCAC 13F .0904(b)(2)	5/23/2022 5/23/2022 5/23/2022

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revealed:
-The resident was in bed and there was a bedside table in front of the resident.
-The resident's meal was on a disposable plate.
-The resident used her left arm/hand to eat because her right arm was paralyzed.
-The disposable plate kept moving across the bedside table and the resident had to reposition the plate back in front of her.
-There were food crumbs scattered across the resident, the bed and the bedside table.

Interview with the resident on 04/06/22 at 12:53pm revealed:
-Most days, her meal was served in the dining room.
-Today, she did not feel like getting up.
-When she did not go to the dining room her food was served on disposable plate ware.
-The disposable plate moved across the table while she was eating, but she would have better control if she was able to use both her hands.

Observation of lunch meal on 04/07/22 at 12:00pm revealed:
-Kitchen staff prepared a cart with two meals on it to be sent to residents who were planning to eat lunch in their rooms.
-The two meals were prepared on disposable plates and there were two beverages that had been poured into disposable cups.

Interview with a PCA on 04/07/22 at 12:01pm revealed that most of the time the kitchen used disposable plate ware to serve meals and beverages to the residents who were eating in their rooms.

Interview with the Dietary Manager (DM) on 04/07/22 at 12:05pm revealed:

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D 287	Continued From page 6 -They did not always serve meals on disposable place settings to residents who chose to eat in their rooms; she thought it was maybe 50% of the time. -There were a couple of residents who were not ready to eat when they were serving lunch, so they sent meals to those two residents on disposable place settings so they could keep their meal in their room until they were ready to eat then just throw it all away when they were done. -The kitchen did not have enough non-disposable plates and cups to serve all of the residents so they chose the residents who were eating in their rooms to receive the disposable place settings. -She had told the Executive Director (ED) within the last couple of months that there was not enough non-disposable plates and cups for all the residents, but more had not been ordered because she had not completed an inventory check yet. Observation of plate supply 04/07/22 at 12:07pm revealed there was one clean non-disposable plate remaining after all residents had been served lunch, with three residents having been served on disposable plates. Interview with a medication aide (MA) on 04/07/22 at 2:55pm revealed the facility had been serving some residents with disposable place settings since early 2020. Interview with a kitchen staff on 04/07/22 at 3:00pm revealed: -They had been serving the residents who ate meals in their rooms on disposable place settings since she had started about a year and a half ago. -She did not know if more non-disposable place settings had been ordered.	D 287		

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D 287	Continued From page 7 Interview with a second MA on 04/07/22 at 4:25pm revealed: -The kitchen served meals to residents who were eating in their rooms on disposable place settings about 50% of the time since she was hired a year and a half ago. -She did not know why they used disposable instead of the non-disposable place settings. -She did not know why some days the residents who ate in their rooms were served on disposable place settings and some days they were served on non-disposable place settings. Interview with the ED on 04/08/22 at 11:30am revealed: -She was aware the kitchen had sometimes served meals on disposable place settings. -She had told the kitchen staff to always use the non-disposable plates and cups. -She advised kitchen staff that if they ran out of non-disposable place settings after the first group of residents ate their lunch, to run some plates and cups through the dishwasher before servings the second group of residents. -The DM was supposed to complete a weekly inventory of place settings but she had not provided one to the ED in a while so she did not know how many place settings they were short.	D 287		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	{D 358}		

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{D 358}	Continued From page 8 which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #5) who had an order for a nerve pain medication. The findings are: Review of Resident #5's hospital FL2 dated 02/23/22 revealed: -Diagnoses included diabetes, schizoaffective disorder and bipolar, and intellectual disability. -There was a medication order for gabapentin (used to treat nerve pain medication) 100mg three times daily. Review of Resident #5's current FL2 dated 03/03/22 revealed: -He was a new admission to the facility on 03/02/22. -Diagnoses included diabetes, schizoaffective disorder and bipolar, and intellectual and developmental disability. -There was no medication order listed for gabapentin. Review of Resident #5's hospital discharge summary dated 03/02/22 revealed there was an order to stop taking gabapentin 100mg which he had been taking up to the day of discharge. Review of Resident #5's March 2022 medication administration record (MAR) revealed there was not an entry for gabapentin on the MAR.	{D 358}	Administrator/Designee will be retrain Med Aides on medication administration and medications errors RCC/Designee will audit MARs to ensure they match all current orders. RCC will assure the all physicians orders are added to MARs upon receipt of new order. RCC/Designee will conduct cart audits once per week x 4 weeks, then once per month ongoing to assure staff are giving medications per physicians' orders. Administrator will audit orders monthly to ensure that MARs match current orders.	5/23/2022 5/23/2022 5/23/2022 5/23/2022 5/23/2022

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{D 358}	Continued From page 9 Review of Resident #5's April 2022 MAR revealed: -There was an entry for gabapentin 100mg take one capsule three times daily at 8:00am, 2:00pm and 8:00pm. -Gabapentin 100mg was documented as administered three times daily from the 8:00am dose on 04/01/22 through the 2:00pm dose on 04/06/22. Observation of Resident #5's medications on hand on 04/07/22 at 10:30am revealed: -There was a medication card for gabapentin 100mg take one capsule three times daily with a dispensed date of 04/02/22 and a dispensed quantity of 27 capsules. -There were 14 capsules remaining out of the 27 capsules that had been dispensed. Telephone interview with a representative from the facility's contracted pharmacy on 04/07/22 at 12:35pm revealed: -They provided MARs for the facility to document medication administration on. -They had provided the MAR for Resident #5 for April 2022 but not for March 2022 because upon admission to the facility, the facility handwrote the medications on the March 2022 MAR. -The FL2 they had on file for Resident #5 was dated 02/25/22 and had been faxed to them on 03/02/22. -They had not received a new order to discontinue Resident #5's gabapentin or seen the hospital discharge order to discontinue the gabapentin, so they had been dispensing gabapentin for him since he was admitted to the facility on 03/02/22. -On 03/02/22 they had dispensed a quantity of 36 gabapentin 100mg capsules (a 12-day supply); on 03/12/22 they had dispensed a quantity of 84	{D 358}		

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gabapentin 100mg capsules (a 28-day supply); and on 04/02/22 they had dispensed a quantity of 27 gabapentin 100mg capsules (a 9-day supply).

Interview with a medication aide (MA) on 04/07/22 at 2:55pm revealed:
-She was familiar with Resident #5 and his medication orders.
-She was aware he was currently taking gabapentin 100mg three times daily.
-The pharmacy had dispensed gabapentin for Resident #5 in March 2022, but since it was not listed on his March 2022 MAR and she did not see it listed on his current FL2, she notified the Resident Care Coordinator (RCC) who advised to have it returned to the pharmacy.
-Since gabapentin had been added to the MAR for April 2022, she had been administering it.
-She did not know if the order was new or why it had been entered on the MAR for April 2022 but not March 2022, she did not know the order had been discontinued upon Resident #5's discharge from the hospital.

Interview with the RCC on 04/07/22 at 4:00pm revealed:
-It was her responsibility to send FL2s and new admission medication orders to the pharmacy.
-She hand-wrote the medications on Resident #5's March 2022 MAR and had not included gabapentin because it had been listed as a discontinued medication on his hospital discharge summary.
-The pharmacy prepared, typed up, and sent the facility Resident #5's April 2022 MAR.
-Gabapentin was not a current order for Resident #5 so he should not be receiving it.
-She was responsible for completing MAR audits each month when the pharmacy sent the next month's MARs; the audit would include

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comparing the current MAR to the following month's MAR to ensure the orders were the same.
-She did an audit for Resident #5's March 2022 to April 2022 MAR but missed where gabapentin had been added to the April 2022 MAR.
-She had not contacted Resident #5's primary care provider (PCP) for clarification on whether or not to discontinue the gabapentin because she did not know that it had been listed as a current medication on the FL2 dated 02/25/22.
-The Executive Director (ED) had faxed the FL2 for Resident #5 from 02/25/22 to the pharmacy, and she had faxed the pharmacy the hospital discharge summary which included the order dated 03/02/22 to discontinue gabapentin along with the FL2 dated 03/03/22 which did not include gabapentin as a current medication for Resident #5.
-She did not know if the pharmacy had not received the fax she sent or why they did not have those documents on file.
-She was aware the pharmacy had sent gabapentin for Resident #5 in March 2022 and had one of the supervisors, she could not remember who, return the medication back to the pharmacy and notified the pharmacy that gabapentin was not a current order for Resident #5.
-She thought one of the MAs must have seen gabapentin listed on Resident #5's April 2022 MAR and since the medication was not available for him in the medication cart, called the pharmacy to request it be sent to the facility.

Interview with a second MA on 04/07/22 at 4:25pm revealed:
-She had not administered Resident #5's medications since gabapentin had been added to the MAR for April 2022 but was familiar with the

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process for refilling medications.
-If there was a medication listed on a resident's MAR but not available in the medication cart, the MA was responsible for documenting on the MAR that the medication as not administered, and then calling the pharmacy to request a refill of the medication.

Telephone interview with a third MA on 04/07/22 at 5:50pm revealed:
-She was aware that Resident #5 was currently taking gabapentin but did not know if the order was new and could not remember if he had been taking that medication since he was admitted to the facility in March 2022.
-She had administered the 8:00am dose of gabapentin 100mg on 04/01/22 but could not remember if she had needed to call the pharmacy to request the medication be sent that day or not.

Telephone interview with a fourth MA on 04/08/22 at 10:20am revealed:
-She was aware that Resident #5 was receiving gabapentin but did not know if he had been receiving that medication since his admission to the facility or not.
-If a medication was listed on a resident's MAR but not available in the medication cart, she would let the RCC know and then contact the pharmacy to request the medication be refilled.
-MAs were able to check resident records to review orders but most of the time the RCC did that for them.

Telephone interview with the ED on 04/08/22 at 11:30am revealed:
-It was the responsibility of either the RCC or herself to process and transcribe new admission orders.
-It had been the RCC who completed the

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	HAL076034	A. BUILDING: _____ B. WING _____	R-C 04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE HAVEN	501 POINTE SOUTH DRIVE RANDLEMAN, NC 27317

(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 358}	Continued From page 13 admission paperwork for Resident #5. -If there was a discrepancy between the hospital FL2 and the new admission medication orders, the RCC would fill out a medication reconciliation form which listed all the current admission orders for the pharmacy. -She had not been aware that the pharmacy dispensed gabapentin for Resident #5. -It was her expectation that the MAs should verify that medication orders were current and active prior to requesting the pharmacy send the medication to the facility. -Both the RCC and herself completed MAR audits every month to compare the current MARs to the new set of MARs sent from the pharmacy for the upcoming month. -Whoever had completed the MAR audit for Resident #5 comparing the March 2022 MAR to the April 2022 MAR must have overlooked the gabapentin entry for April 2022. -She had not clarified the order with Resident #5's PCP because she did not realize the gabapentin was discontinued on the hospital discharge paperwork but was listed as a current medication on the medication reconciliation form and FL2 dated 02/25/22. Attempted interview with Resident #5's PCP on 04/07/22 at 3:15pm was not successful. Based on record review and attempted interview, it was determined that Resident #5 was not interviewable.	{D 358}		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM	D 612		

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D 612	Continued From page 14 (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. This Rule is not met as evidenced by: Based on observations, 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 (NCDHHS) were implemented and maintained to provide protection to residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemasks (source control). The findings are: Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed: -Source control measures were to be implemented for HCP. -Source control referred to the use of a well-fitting facemask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they were breathing, talking, sneezing, or	D 612	Administrator re-trained staff on Infection Prevention and Control Recommendations for Healthcare Personnel, including but not limited to wearing facemasks. RCC/Administrator will monitor x 5 days per week to ensure guidance from local health department, cdc and NCDHHS is followed.	5/23/2022 5/23/2022

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D 612	Continued From page 15	D 612		

coughing.
-Cloth facemasks were not personal protective equipment (PPE) appropriate for use by HCP.
-Fully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents.

Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention for Long-Term Care Facilities dated 11/19/21 revealed:
-Source control referred to the use of well-fitting facemasks to cover a person's mouth and nose.
-Cloth masks were not considered PPE and should not be worn by staff.

Review of the facility's COVID-19 policies revealed:
-In-service training should be provided to assure all staff understand the guidance related to the proper use of PPE including face masks.
-Cloth face coverings were not PPE.

a. Observation of the second shift medication aide (MA) on 04/06/22 at 3:55pm revealed:
-The MA was in the hallway at the medication cart.
-The MA's face mask was down past her nose.
-The MA prepared a resident's medication and went into the resident's room.
-The MA administered the medication to the resident and left the room.
-The MA rolled the medication cart down the hallway and continued to administer several more residents their medications with her face mask below her nose.
-At 4:13pm, the MA was sitting in a chair at the bedside of a non-ambulatory resident.
-The MA's face mask was pulled down past her nose and mouth.

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D 612	Continued From page 16 -The MA was administering the resident morphine via a syringe under the tongue. -The MA was communicating and talking with the resident with another staff standing in the hallway by the medication cart. -The MA did not pull her face mask up until she saw the surveyor in the hallway. -The MA pulled her face mask up over her mouth but her nose was still uncovered. Telephone interview with the MA on 04/08/22 at 10:07am revealed: -She pulled her face mask down for a minute because her nose was itching. -She uncovered her nose and mouth because she was hot and could not breathe. -Her face mask fits fine, every now and then she got hot and took the face mask down for a minute, but she always pulled it back up. -She thought it was last month when the facility provided training regarding wearing PPE. -She knew that she was supposed to keep her face mask on, but she had to take it down for a minute. -She was aware that her face mask should not come off when in the presence of residents. -She had both COVID-19 vaccines and was scheduled to get the booster shot next month. -She had not told management that she was having a difficult time breathing with the face mask. b. Observation of a personal care aide (PCA) on 04/06/22 from 3:45pm to 4:01pm revealed: -At 3:45pm, the PCA was in the hallway and pulled her face mask down below her mouth and nose. -The PCA verbally said out loud "it's hot." -At 3:55pm, the PCA was observed walking in the hallway past residents with her face mask below	D 612		

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D 612	Continued From page 17 her nose. Telephone interview with the PCA on 04/06/22 at 10:30am revealed: -The facility had provided training on the proper way to wear PPE (face masks). -It got hot in the facility and it was hard for her to breathe so she had to take the face mask off. -She sometimes pulled the face mask below her nose to help with breathing. -The Executive Director (ED) had told staff multiple times to keep their face masks on. -The ED told her if she wanted to take the face mask off to step outside. Telephone interview with the ED on 04/08/22 at 11:18am revealed: -Staff had been told they were always to a face mask when in the facility. -When she saw staff with their face mask down past their nose, she continually told them to pull the face mask up. -At all meetings, staff were reminded to keep their face mask above their nose.	D 612		