Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065023	A. BUILDING: _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE KEMPTON AT BRIGHTMORE	2298 S 41ST STREET WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 06/29/22 to 06/30/22.	D 000	**The following is a Plan of Correction for The Kempton at Brightmore. This Plan of Correction is in regards to the Statement of Deficiencies resulting from the annual survey completed on June 30, 2022. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.** **To remain incompliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.**	08/01/2022
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 notify the healthcare provider for 1 of 5 sampled residents (#1) of shortness of breath requiring the use of oxygen and symptoms of continued depression after starting a medication used to treat depression. The findings are: Review of Resident #1's current FL-2 dated 04/25/22 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), asthma, chronic bronchitis, history of tuberculosis, hypertension (HTN), and diastolic heart failure, and cerebral infarction. -The resident was ambulatory. Review of Resident #1's current care plan dated 04/28/22 revealed: -The resident's orientation was good and memory adequate. -The resident was independent with ambulation using a walker, and transfers a. Review of Resident #1's current FL-2 dated 04/25/22 revealed:	D 273	**D 273 Corrective Action for Affected Resident** Resident #1 received an order on June 29, 2022 for continuous oxygen at 2L per minute at hours of sleep and PRN daily via nasal cannula for shortness of breath. Resident #1 received a referral for Life Source on July 6, 2022. Resident was seen by Life Source on July 20, 2022.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa M Crouch
TITLE: Administrator
(X6) DATE: 07/27/2022

Reviewed and Acknowledged
on 08/04/2022

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D 273	Continued From page 1 -The resident's respirations were normal. -There was no order for oxygen therapy. Review of Resident #1's current care plan dated 04/28/22 revealed: -The resident required oxygen 2 liters (L) nasal cannula during sleep. -There was documentation oxygen was to be applied at night and removed in the morning. Review of a facility's fax to Resident #1's Primary Care Provider (PCP) dated 04/26/22 revealed: -There was a request for the resident's PCP to sign a medication clarification. -Attached to the fax cover sheet was Resident #1's signed order for oxygen 2L continuous via nasal cannula at bedtime for shortness of breath dated 04/28/22. Review of Resident #1's Licensed Health Professional Support (LHPS) assessment dated 04/28/22 revealed: -Staff administered the resident oxygen 2L at night and removed in the morning. -The resident received oxygen 2L nasal cannula as needed for shortness of breath. -Staff monitored the resident for shortness of breath. -The residents PCP would be notified with any changes. Review of the facility's electronic progress notes for Resident #1 from 04/27/22 to 06/27/22 revealed: -On 04/27/22, it was documented Resident #1 was admitted to the facility and required continuous oxygen; the resident's lungs were weak. -There was no other documentation regarding shortness of breath, wearing continuous or as	D 273	Therapist recommended psychotherapy treatment and initiating psychiatric medication management to assist in administering most safe and effective medication. **D 273 Corrective Action for Potentially Affected Residents** On 7/26/2022 an audit was completed for all residents that have oxygen to ensure the concentrator and/or portable tanks are set according to physician orders. On 7/26/2022 an audit of all residents currently receiving medications to treat depression and/or anxiety was completed to ensure improvement of symptoms and effectiveness. If ongoing symptoms residents were referred to the physician for additional medication management and asked for a referral for Life Source. **D 273 Systematic Changes** Beginning on 7/20/2022, the Director of Nursing provided an in-service education to all med techs on signs and symptoms of shortness of breath, monitoring/checking oxygen concentrator settings, documenting mood/behavior for all anti-psychotic and anti-depressant	

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D 273	Continued From page 2 needed oxygen, or PCP notification regarding shortness of breath. Review of Resident #1's respiration summary from 04/27/22 to 06/27/22 revealed the resident's respirations ranged from 14 to 22 breaths per minute. Review of Resident #1's pulse oximetry (measures the amount of blood oxygen; normal range is 95 % to 100%) summary from 04/27/22 to 06/29/22 revealed the resident sustained a pulse oximetry of 96% to 99% on room air. Observation of Resident #1 and her room on 06/29/22 at 9:35am revealed: -The resident stood from a chair and had broken speech. -There was an oxygen concentrator with a nasal cannula attached beside the head of her bed. -The oxygen concentrator was not on and was set at 1.5 liters per minute. -The resident was not wearing oxygen. Interview with Resident #1 on 06/29/22 at 9:39pm revealed: -She asked to see the facility nurse yesterday because she was shorter of breath than normal and thought she had pneumonia. -She had not yet seen the facility nurse. -She was always supposed to wear oxygen because she had shortness of breath and was going to put on her oxygen shortly. -Staff did not apply her oxygen. A second observation of Resident #1 on 06/29/22 at 3:00pm revealed: -She was sitting in her room wearing oxygen 1.5L via nasal cannula. -The resident's speech was clear but paused to	D 273	medications, and making Life Source referrals. This training will be incorporated into the orientation process for new hire staff. The med tech will check the oxygen flow for the concentrator and/or portable tank every shift and document on the MAR. The med tech will complete behavior monitoring for all depression and/or anxiety medications each shift. Any abnormal findings will be reported to the director of nursing for further evaluation as needed. The Director of Nursing or designee will complete an audit of all oxygen concentrators and/or portable tanks and review the behavior monitoring for all depression and/or anxiety mediations.. The audit will be completed weekly for 4 weeks and then monthly for 2 months. **D 273 Title of person responsible for implementing plan of correction.**	

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D 273	Continued From page 3 catch her breath between words. Interview with Resident #1 on 06/29/22 at 3:00pm revealed: -She was currently short of breath and became shorter of breath with ambulation. -She put on her oxygen today after lunch because she was short of breath. -A female doctor told her she should always wear oxygen because of having shortness of breath and respiratory problems. -She did not know who the doctor was or when. -Facility staff knew she was short of breath because they observed her having shortness of breath during her baths and when getting dressed. -Two weeks ago, she walked to the dining room without oxygen and became short of breath and felt she was going to pass out. -She was too weak to walk, and facility staff had to push her back to her room. -Staff placed a device on her finger at that time and the reading was low along with her blood pressure. -She had not seen her PCP for shortness of breath. Interview with a personal care aide (PCA) on 06/29/22 at 3:20pm revealed: -A few weeks ago, Resident #1 told her she was instructed by her PCP to always wear oxygen. -She never placed oxygen on Resident #1. -She had never seen Resident #1 with shortness of breath. Telephone interview with a nurse at Resident #1's PCP office on 06/29/22 at 3:30pm revealed: -Resident #1 was treated on 06/14/22 for a constant cough and sinus complaints. -There was no documentation the facility notified	D 273	Reports will be presented to the weekly Quality of Life committee by the Administrator or designee to ensure corrective action initiated as appropriate and extended if indicated. The Administrator is responsible for implementation and completion of the acceptable plan of correction. Completion date: 8/1/2022	

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D 273	Continued From page 4 the resident's PCP the resident had shortness of breath or wore oxygen as needed for shortness of breath during wake hours. -The resident had no PCP appointments after 06/14/22. -Resident #1's PCP was unavailable for interview. Review of the facility's physician visit form for Resident #1 dated 06/14/22 revealed: -The resident had crackles that resolved with deep breathing. -The resident's chest x-ray was normal. -A nasal steroid was recommended for post-nasal drip. -There was no documentation of shortness of breath or an order for oxygen as needed during wake hours. Interview with the facility's registered nurse (RN) on 06/29/22 at 3:45pm revealed: -She was not aware Resident #1 requested to see her on 06/28/22. -She did not remember being informed by staff Resident #1 became short of breath, weak, and felt she would pass out and staff had to push her to her room from the dining room. -The MA on duty would have documented Resident #1's shortness of breath requiring staff assistance in the resident's facility charting notes. -Resident #1 would become a little short of breath at times and stopped to catch her breath. -Resident #1 applied her own oxygen at night if she felt she needed it. -Resident #1 also wore oxygen most of the day because of shortness of breath. -Resident #1's PCP should have been notified by the MA immediately via telephone or fax that the resident was short of breath requiring the use of oxygen at times other than when ordered. -She would need to review Resident #1's facility	D 273		

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D 273	Continued From page 5 progress notes to determine if the resident's PCP was notified. -Resident #1's shortness of breath incident would have occurred during the resident's adjustment time frame because she was still considered a new resident in the facility. -She was ultimately responsibility for all PCP notifications. -She did not answer when asked if she notified Resident #1's PCP of shortness breath. Interview with the Administrator on 06/29/22 at 4:45pm revealed she expected staff to notify Resident #1's PCP when the resident was observed short of breath. Interview with the medication aide (MA) on 06/29/22 at 4:50pm revealed she did not know until today that Resident #1 had shortness of breath. Attempted telephone interview with Resident #1's family member on 06/29/22 at 2:17pm was unsuccessful. b. Review of Resident #1's current care plan dated 04/28/22 revealed: -The resident was not under the care of a mental health provider. -The resident was not prescribed medications for mental illness or behavior. Review of Resident #1's facility progress notes dated 05/27/22 revealed: -There was documentation the resident was crying and sad. -The resident stated she had nothing, and all her things were taken from her. -The resident's Primary Care Provider (PCP) was faxed asking for medication to calm her.	D 273		

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D 273	Continued From page 6 Review of the facility's physician communication form for Resident #1 dated 05/27/22 revealed: -There was a section titled "Health Care Concerns" which included documentation Resident #1 had a hard time adjusting, was crying and sad, and felt lost. -There was documentation the resident reported she had nothing, and her things were taken from her. -There was a section titled "Question" which included documentation asking if the facility could have something to calm the resident. -There was an order for Zoloft 25mg daily signed by the resident's PCP and dated 05/31/22 (used to treat depression; can take 4 to 6 weeks to reach the full effects; initial effects may begin within the first 1 to 2 weeks of treatment). Review of the facility's fax transmission form for Resident #1 dated 06/03/22 revealed: -There was a section titled "Comments" which included documentation asking for a diagnosis for the Zoloft. -Diagnosis included depression. Observation of Resident #1 on 06/29/22 at 3:00pm revealed: -She was sitting in a chair in her room; her eyes were glassy and red. -She did not smile with conversation. -She was cutting up documents. Interview with Resident #1 on 06/29/22 at 3:00pm revealed: -Her family member died about six months ago. -She was cutting up documents that belonged to a former family member. -She was not happy living at the facility and wanted to go home but she no longer had a	D 273		

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D 273	Continued From page 7 home. -She could no longer care for herself. -She cried at times. -She ate lunch in her room because she did not want to socialize today. -She was happy eating in her room. Interview with a medication aide (MA) and facility transporter on 06/29/22 at 2:30pm revealed: -Resident #1 cried three to four times a week after being admitted to the facility. -Resident #1 was prescribed Zoloft for depression shortly after she arrived at the facility. -Resident #1's mood improved some after being prescribed Zoloft but was Resident #1 was still "very depressed" most of the time due to having to give up her home and move to the facility. -Now, Resident #1 cried about one to two times weekly, and said she all her belongings were taken away and had nothing since being at the facility. -She consoled Resident #1, her crying and sadness would get better, but it would not last long. -She told the facility registered nurse (RN) Resident #1 was still depressed and cried (the date was not provided). -The facility RN directed her to continue to monitor Resident #1 for sadness and crying and notify her PCP if she felt the resident needed medication changes for depression. -She knew Resident #1 needed medication changes for depression if she slipped into "deep depression" or if redirection did not help. -Deep depression was an indicator of redirection not helping and would be apparent if the resident stopped eating meals in the dining room and stopped participating in activities. -She did not notify Resident #1's PCP the resident displayed symptoms of continued	D 273		

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D 273	Continued From page 8 depression because the facility RN directed her to continue to monitor the resident for sadness and crying. -Currently, Resident #1 had her meals in the dining room and participated in facility activities. Telephone interview with a nurse at Resident #1's PCP office on 06/29/22 at 3:30pm revealed the facility had not notified the resident's PCP that the resident had continued crying or withdrawal symptoms after being prescribed Zoloft in May 2022. Interview with the facility's RN on 06/29/22 at 3:45pm revealed: -Resident #1's family member died about six months to one year ago. -Resident #1 cried when she was first admitted because she did not want to be at the facility. -Resident #1 did not cry as often now and participated in activities. -The facility had a stand-up meeting last week and staff did not report Resident #1 as being sad or crying. -She was not told by the MA Resident #1 still cried or was depressed. -The MA was responsible to notify Resident #1's PCP if the resident was sad or cried weekly. Interview with the Administrator on 06/29/22 at 4:45pm revealed: -Resident #1 had not been evaluated by mental health. -She was not informed by staff Resident #1 cried one to two times a week. -She expected staff to notify Resident #1's PCP if the resident cried weekly. A third interview with the facility RN on 06/29/22 at 4:48pm revealed:	D 273		

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D 273	Continued From page 9 -She thought Resident #1 was sad about one or two times since admission. -She did not think Resident #1 had been sad recently. Interview with the facility's Quality and Assurance (QA) nurse on 06/30/22 at 1:43pm revealed: -Resident #1 was prescribed Zoloft the end of May 2022 because of tearfulness. -It took about six weeks for Zoloft to begin to show an effect. -She did not expect facility staff to notify Resident #1's PCP of crying one to two times a week because the Zoloft did not have time to get into the resident's system. -Staff were to notify Resident #1's PCP if she were on Zoloft for six weeks or more and the resident still had crying spells. -A referral order for Resident #1 to be evaluated by mental health was required from the resident's PCP before an appointment could be made for the resident with the mental health provider. -When residents were prescribed medications such as Zoloft, a behavior modification order was to be entered in the electronic treatment record by the MA. -A PCP order was not required because the behavior modification treatment was a facility protocol -When entered, the behavior modification treatment order would prompt the MA to document certain behaviors. -Today (06/30/22) staff entered a behavior modification order for Resident #1. -Resident #1 did not have a behavior modification treatment order entered in her electronic treatment record that would allow staff to track those specific behaviors prior to today because the MA failed to enter.	D 273		

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D 273	Continued From page 10 Attempted telephone interview with Resident #1's family member on 06/29/22 at 2:17pm was unsuccessful.	D 273		