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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on January 18, 2023 through January 20, 2023.	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 referral and follow up to meet the healthcare needs for 1 of 5 sampled residents (#3) related to obtaining routine International Normalized Ratio (INR) laboratory results and changes to a blood thinner (warfarin) dosage. The findings are: 1. Review of Resident #3's current FL-2 dated 09/21/22 revealed: -Diagnoses included Type 2 Diabetes Mellitus, and unspecified Atrial Fibrillation (AFib). -There was an order for Coumadin 5mg (a blood thinner used to treat AFib) daily. (Warfarin is generic for Coumadin). (Warfarin is dosed based on an International Normalized Ratio (INR) laboratory value with 2.0 to 3.0 being the target range for treating AFib according to the American College of Chest Physicians Evidence-Based Clinical Practice Guidelines.) Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/19/23 at 1:45pm regarding Resident #3's warfarin orders at the pharmacy revealed:	D 273		

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D 273	Continued From page 1 -The pharmacy did not generate the medication administration records (MARs) for residents at the facility; the facility had their own computer system to document medication administration. -The contracted pharmacy maintained a medication profile for residents based on orders received from the facility or providers, and dispensed medications according to their medication profile. -The facility was responsible to fax all medication orders to the pharmacy in a timely manner. -On 11/04/22, Resident #3's warfarin order from Resident #3's primary was warfarin 5mg on Monday(M), Wednesday(W), Friday(F), Saturday(Sa) and Sunday(Su); Warfarin 7.5mg on Tuesday(Tu) and Thursday(Th) with a documented INR of 1.9. -On 01/09/2023, the pharmacy received a faxed order from the facility from Resident #3's primary care provider (PCP) dated 12/19/22 to change Resident #3's warfarin to 5mg daily based on an INR of 2.9. -The contracted pharmacy had no additional warfarin orders documented for Resident #3. Telephone interview with a nurse at Resident #3's PCP office on 01/19/23 at 1:55pm revealed: -Resident #3's INR values were obtained by a local home health agency. -The office had several INR values along with orders for warfarin and the next scheduled INR checks. -Warfarin information provided by the nurse was as follows: -On 11/04/22, INR was 1.9 with warfarin dose ordered 5mg on M, W, F, Sa, and Su; 7.5mg on Tu and Th. Recheck INR in 2 weeks. -On 11/17/22, INR was 2.1 with warfarin dose ordered 5mg on M, W, F, Sa, and Su; 7.5mg on Tu and Th. Recheck INR in 2 weeks.	D 273		

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-On 12/01/22, INR was 2.1 with warfarin dose ordered 5mg on M, W, F, Sa, and Su; 7.5mg on Tu and Th. Recheck INR in 2 weeks.
-On 12/19/22, INR was 2.9 with warfarin dose change ordered for 5mg daily. Recheck INR in 4 weeks.
-On 01/17/23, there was an order to hold warfarin today (01/17/23), tomorrow (01/18/23) and Thursday (01/19/23); resume after surgery on 01/20/23.

Review of Resident #3's warfarin orders from his PCP and home health notes available for review at the facility revealed:
-On 11/04/22, INR was 1.9 with warfarin dose ordered 5mg on M, W, F, Sa, and Su; 7.5mg on Tu and Th. Recheck INR in 2 weeks.
-On 12/19/22, INR was 2.9 with warfarin dose change ordered for 5mg daily. Recheck INR on 01/16/23 was documented on an order sent on 12/19/22 at 4:18pm to the Home Health agency with a fax date stamp received at the facility on 01/02/23.
-On 01/12/23, there was a Home Health agency note documenting "INR 2.9 confirmed with PCP office; warfarin dose 5mg daily.
-On 01/17/23, there was an order to hold warfarin today (01/17/23), tomorrow (01/18/23) and Thursday (01/19/23); resume after surgery on 01/20/23.
-There were no additional physician orders for warfarin or INR rechecks available for review at the facility.

Review of the facility's INR flow sheet for Resident #3 documented warfarin activity revealed:
-On 11/04/22, current dose was 5mg daily, INR was 1.9 and new dose was warfarin 5mg on M, W, F, Sa, and Su; 7.5mg on Tu and Th.

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-On 12/19/22, current dose was 5mg on M, W, F, Sa, and Su; 7.5mg on Tu and Th, INR was 2.9 with new dose documented as 5mg daily and comment "Family delivered order 01/02/23.
-On 01/03/23, current dose was 5mg daily, placed on 5mg on 01/03/23 was documented.
-On 01/12/23, current dose was 5mg daily, INR 2.9 from Home Health order verifying dose.
-On 01/17/23, current dose was 5mg daily, hold for surgical procedure.

Review of Resident #3's November 2022 facility generated electronic Medication Administration Record (eMAR) revealed:
-There was an entry for warfarin 5mg on M, W, F, Sa, and Su; 7.5mg on Tu and Th beginning on 11/04/22.
-Warfarin was documented administered as ordered from 11/04/22 to 11/30/22.

Review of Resident #3's December 2022 facility generated eMAR revealed:
-There was an entry for warfarin 5mg on M, W, F, Sa, and Su; 7.5mg on Tu and Th from 12/01/22 to 12/31/22.
-There was no entry for warfarin 5mg daily beginning on 12/19/22.
-There were 4 doses of warfarin 7.5mg documented as administered and should have been 5mg on 12/20/22, 12/22/22, 12/27/22 and 12/29/22.

Review of Resident #3's January 2023 facility generated eMAR revealed:
-There was an entry for warfarin 5mg on M, W, F, Sa, and Su; 7.5mg on Tu and Th from 01/01/23 to 01/04/23.
-There was an entry for warfarin 5mg daily beginning on 01/04/23.
-There was 1 dose of warfarin 7.5mg

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documented as administered and should have been 5mg on 01/03/23.

Interview with the Administrator on 01/19/23 at 3:00pm revealed:
-She was a nurse as well as the Administrator.
-The facility routinely had a Health and Wellness Director (HWD) that was a nurse.
-Due to staffing shortage she had been several months without a HWD and had been staffing as the HWD as well as the Administrator.
-She knew warfarin required routine INR monitoring to maintain therapeutic dose range.
-The Home Health agency nurse obtained INR value and notified Resident #3's PCP.
-The Home Health agency had been managing Resident #3's warfarin including notifying the PCP and obtaining orders for warfarin doses.
-She thought the Home Health agency was sending the facility a copy of the PCP's orders for warfarin as well as orders for the INR recheck for tracking.
-There was a lead medication aide (MA) on the evening shift that had been logging warfarin orders in the facility's INR flow sheet for Resident #3.
-The Administrator had not audited the facility's INR flow sheet for Resident #3 for tracking.
-There were no PCP orders for rechecks of INR available for review except the order Resident #3's family member turned into the facility on 01/02/23 that was dated 12/19/22.

Interview with the MA completing documentation of warfarin orders in the facility's INR flow sheet for Resident #3 on 01/19/23 at 4:50pm revealed:
-She recently accepted responsibility for logging warfarin orders for Resident #3 on the facility's INR flow sheet.
-She documented the date an order was

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received, the current dose, then INR provided on the order, any new warfarin dose ordered.
-She did not know to ensure INR rechecks were scheduled and documented.
-She had contacted Resident #3's PCP or the facility's Home Health agency for INR values from rechecks or warfarin orders for each recheck.

Telephone interview with the Clinical Nurse of the facility's Home Health agency on 01/20/23 at 8:40am revealed:
-The Home Health agency was responsible to obtain Resident #3's INR values, contact the resident's PCP and relay the INR value and obtain any warfarin changes.
-The PCP's orders included information for the ordered next INR recheck.
-The Home Health agency used to transfer all orders and data to the facilty electronically on the evening orders were received.
-The Home Health agency was under new management and was not routinely sending the facility a copy of the orders.
-The Home Health agency staff logged in the facility provider sign in sheet when they came to the building.
-The Home Health agency notes documented INR checks and scheduled rechecks as follows: on 11/17/22, INR was 2.1 recheck 2 weeks; on 12-01-22, INR was 2.1 recheck in 2 weeks; on 12/15/22 INR was 2.1 recheck on 12/19/22; on 12/19/22, INR was 2.9 recheck in 4 weeks; on 01/17/23, INR was 2.9 recheck in 4 weeks after holding for surgery.
-There was no documentation for contact from the facility to request INR results, next scheduled rechecks, or the warfarin dose from 11/04/22 until 01/19/23.

Interview with the Health and Wellness Director

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D 273	Continued From page 6 (HWD) on 01/20/23 at 11:10am revealed: -She started her current position as HWD on 12/27/22. -She trained at an outside sister facilty for two weeks and had been working in the facility about one week. -The facility did not previously have a system in place to monitor residents on warfarin including tracking the current INR, current order, next scheduled INR and any warfarin changes after INR checks. -There was no routine system for tracking and documenting PCP follow-ups or ensuring referrals, like scheduled INR for Resident #3, were completed. Interview with a Home Health agency nurse obtaining an INR for Resident #3 on 01/20/23 at 12:00pm revealed: -She obtained Resident #3's INR on several occasions. -She did not routinely leave orders for INR rechecks or PCP orders for warfarin. -She thought the contracted pharmacy would send a copy of Resident #3's orders to the facility. -She planned to discuss a better system with Home Health agency and the facility for follow-up.	D 273		
D 618	10A NCAC 13F .1802 (a) Reporting & Notification of a Suspected or C 10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK (a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public	D 618		

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D 618	Continued From page 7 Health as specified in 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report confirmed cases of COVID-19 to the local health department (LHD) immediately upon finding out a resident had tested positive for COVID-19. The findings are: Observation during the initial facility tour on 01/18/23 from 8:45am to 11:00am revealed there were 3 residents' room with signs posted for COVID-19 precautions and personal protective equipment (PPE) in plastic storage bins outside the residents' doors. Review of CDC Guidance Interim Infection Prevention and Control Recommendations to COVID-19 spread in Nursing Homes and Long-Term Care Facilities dated 02/02/22 revealed notify the LHD promptly of 1 resident or staff with suspected or confirmed SARS-CoV-2 infection. Review of the COVID-19 Pandemic Response, Laboratory Data Reporting: CARES (Coronavirus Aid, Relief, and Economic Security) Act effective 04/04/22 requires every laboratory in a setting operation under a Clinical Laboratory Improvement Amendments (CLIA) certificate waiver must report positive test results to state, territorial, local, and Tribal (STLT) public health department.	D 618		

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D 618	Continued From page 8 Review of a memo from the NC Department of Health and Human Services (NCDHHS) Division of Health Service Regulation (DHSR) dated 11/21/22 revealed: -The Adult Care Home Administrator or his/her designee must report all suspected communicable disease outbreaks to the local health department. -A suspected communicable disease outbreak is defined as any illnesses among residents with same identifiable infectious cause (e.g. evidence of the same virus found on laboratory testing). -Reports must be made by phone within 24 hours of the time when the outbreak is reasonably suspected to exist. Interview with the Administrator on 01/18/23 at 10:20am revealed: -The facility had 3 residents currently quarantined for positive COVID-19 test results performed by the facility. -The facility delivered meals to the COVID-19 positive residents' room and the residents had bathing and toileting fixtures in their rooms. -All residents and staff were tested beginning 12/21/22 and residents and staff negative for COVID-19 were tested weekly thereafter. Telephone interview with the LHD nurse on 01/18/23 at 4:20pm revealed: -She was not aware there were any COVID-19 positive cases at the facility. -The facility had not notified the LHD regarding outbreak status for COVID-19. -The facility staff should have reported the first four positive COVID test on 12/21/22 within 24 hours. -The facility staff should have started testing all residents immediately and retested the residents	D 618		

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with negative COVID-19 at no more than one week later.
-The facility would be in outbreak status until all negative residents were tested with 2 weekly tests and there were no new positive COVID-19 test result for 2 weekly tests (14 days).
-She had communicated guidance on how to handle COVID-19 cases to facility staff during a recent COVID-19 outbreak earlier in the year in the facility.

Interview with the facility's Administrator on 01/20/22 at 10:30am revealed:
-She was responsible to ensure the COVID-19 protocol was followed in the facility.
-The facility had five residents with confirmed active cases of COVID-19 in the facility and 11 recovered cases (over 10 days old) beginning on 12/20/22 to 01/20/23.
-The first 4 residents tested positive on 12/20/22.
-A staff member tested positive on 12/21/22.
-Another staff tested positive on 12/24/22.
-A third staff member tested positive on 12/28/22.
-The fifth and sixth resident tested positive on 12/29/22.
-The 7th resident tested positive on 01/03/23.
-The 8th resident tested positive on 01/09/23.
-The 9th resident tested positive on 01/10/23.
-The 10th resident tested positive on 01/13/23.
-The 11th resident tested positive on 01/16/23.
-The 12th and 13th residents tested positive on 01/18/23.
-She had not reported the resident cases of COVID-19 to the LHD.
-She thought there had to be at least 2 confirmed cases of COVID-19 before reporting to the LHD as an outbreak.
-She had completed an electronic COVID-19 reporting form and emailed it to the LHD on 12/20/22.

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D 618	Continued From page 10 -Apparently she did not process the electonic form correctly because she did not use the submit key after she completed the form. -She started weekly COVID-19 testing on 12/20/21 but did not use the county health department line tracking sheet for documenting and reporting to the health department as she had done at earlier COVID-19 outbreaks. -She had not followed up with the LHD nurse regarding current county health department for any new or current guidelines or recommendations for COVID-19 outbreak control.	D 618		
D 619	10A NCAC 13F .1802 (b) Reporting & Notification of a Suspected or C 10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK (b) The facility shall provide the residents and their representative(s) and staff with an initial notice within 24 hours following confirmation by the local health department of a communicable disease outbreak. The facility, in its initial notification to residents and their representative(s), shall: (1) not disclose any personally identifiable information of the residents or staff; (2) provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change; and (3) provide information to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection.	D 619		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to inform residents and their representatives within 24 hours following one or more confirmed cases of COVID-19 among any resident or staff person.

The findings are:

Review of CDC Guidance Interim Infection Prevention and Control Recommendations to COVID-19 spread in Nursing Homes & Long-Term Care Facilities dated 09/10/21 revealed the facility shall notify healthcare providers, residents and families promptly about identification of COVID-19 in the facility and maintain ongoing and frequent communication with residents and families with updates on the situation and facility's actions.

Observation during the initial facility tour on 01/18/23 from 8:45am to 11:00am revealed there were 3 residents' rooms with signs posted for COVID-19 precautions and personal protective equipment (PPE) in plastic storage bins outside the residents' doors.

Interview with the facility's Administrator on 01/20/22 at 10:30am revealed:
-She was responsible to ensure COVID-19 protocol was followed in the facility.
-The facility had 5 residents with confirmed active cases of COVID-19 in the facility and 11 recovered cases (over 10 days old) beginning on 12/20/22 to 01/20/23.

Telephone interview with a resident's family member from a telephone call placed 01/20/23 at

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BROOKDALE SKEET CLUB	1560 SKEET CLUB ROAD HIGH POINT, NC 27265

(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 619	Continued From page 12 11:50am revealed: -He was not made aware that there was currently COVID-19 cases in the facility. -He had not received information from the facility regarding residents that tested positive for COVID-19 on 12/20/22 or subsequently. -He would liked to have been informed the facility had active COVID-19 residents due to his own compromised immune system and taking extra precautions when visiting his family member. Interview with a second family member on 01/20/23 at 12:10pm revealed: -She had not received information from the facility regarding residents that tested positive for COVID-19 on 12/20/22 or subsequently. -She would liked to have been informed the facility had residents that tested positive for active COVID-19 when the first outbreak was identified. -She would have been taking extra precautions when visiting her family member. Second interview with the Administrator on 01/20/23 at 12:30pm revealed she did not notify the resident's family members that there was COVID-19 in the facility because she was not aware that she was required to. [Refer to Tag D 0168, 10A NCAC 13F.1802(a), Reporting and Notification of a Suspected or Confirmed Communicable Disease Outbreak (Deficient Practice)].	D 619		