

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey, and complaint investigation on May 14, 2024 through May 17, 2024 and May 20, 2024.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 6 sampled staff (Staff D, E and F) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: 1. Review of Staff D's personnel record on 05/20/24 revealed: -Staff D was hired on 02/19/20 as a medication aide (MA). -There was no documentation a HCPR check was completed prior to Staff D's hire on 02/19/20. -Review of Staff D's HCPR dated 05/20/24 revealed there were no substantial findings. Refer to the interview with the Business Office Manager (BOM) on 05/20/24 at 3:39pm. Refer to the interview with the Administrator on 05/20/24 at 7:27pm.	D 137		

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

TITLE

(X6) DATE

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D 137	Continued From page 1 2. Review of Staff E's personnel record on 05/20/24 revealed: -Staff E was hired on 08/30/23 as a medication aide (MA). -There was no documentation a HCPR check was completed prior to Staff E's hire on 08/30/23. -Review of Staff E's HCPR dated 05/20/24 revealed there were no substantial findings. Refer to the interview with the Business Office Manager (BOM) on 05/20/24 at 3:39pm. Refer to the interview with the Administrator on 05/20/24 at 7:27pm. 3. Review of Staff F's personnel record on 05/20/24 revealed: -Staff F was hired on 08/30/23 as a medication aide (MA). -There was no documentation a HCPR check was completed prior to Staff F's hire on 08/30/23. -Review of Staff F's HCPR dated 05/20/24 revealed there were no substantial findings. Refer to the interview with the Business Office Manager (BOM) on 05/20/24 at 3:39pm. Refer to the interview with the Administrator on 05/20/24 at 7:27pm. Interview with the Business Office Manager (BOM) on 05/20/24 at 3:29pm revealed: -She had been employed as the BOM at the facility since 12/06/23. -She was responsible for making sure all staff had HCPR verification. -All staff hired since her employment in December 2023 had HCPR verification. -She was not aware that Staff D, E and F did not	D 137		

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D 137	Continued From page 2 have HCPR verification. -It was important for all staff to have HCPR verification to ensure the safety of the residents. -She would check the HCPR for Staff D, E and F today. Interview with the Administrator on 05/20/24 at 7:27pm revealed: -The BOM was responsible for maintaining personnel records and ensuring HCPR checks were completed upon hire. -A HCPR check should have been completed for all staff upon their hire date. -A HCPR check was important to make sure there were no allegations or reports of abuse. -The HCPR check was important to ensure the residents were safe and protected.	D 137		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a) (1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior	D 161		

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D 161	Continued From page 3 to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 personal care aides (Staff C) and 2 of 3 medication aides (Staff E, and F) had been competency validated for licensed health professional support (LHPS) tasks by return demonstration including urinary catheter care, and to provide transfer assistance to non-ambulatory a resident. The findings are: 1. Review of Resident #7's current FL2 dated 04/16/24 revealed: -Diagnoses included congestive heart failure, atrial fibrillation, peripheral arterial disease, and abnormal gait. -The resident had an order for an indwelling catheter and was continent of bowel. -The resident needed assistance with bathing and dressing. -The resident's current level of care was Assisted Living. Review of Resident #7's Home Health (HH) progress notes revealed: -On 04/19/24 Resident #7's vital signs were within normal limits, the catheter was last changed on 04/15/24 and wound care provided with no issues. -On 04/24/24 HH performed wound care and assessed catheter site and placed a new	D 161		

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D 161	Continued From page 4 securement device. -Some irritation and blood noted at insertion site due to line pulling, adjusted and corrected problem and report given to the Health and Wellness Director (HWD). Observations of Resident #7 on 05/16/24 at 3:08pm revealed: -He was sitting in his recliner in his apartment. -His catheter bag hung next to the recliner off the floor. Review of Staff C's personnel record revealed: -Staff C was hired on 12/28/22 as a personal care aide (PCA). -There was no documentation Staff C completed an LHPS competency Validation to perform urinary catheter care. Review of Staff E's personnel record revealed: -Staff E was hired on 08/30/23 as a medication aide (MA). -There was no documentation Staff E completed an LHPS competency Validation to perform urinary catheter care. Review of Staff F's personnel record revealed: -Staff F was hired on 08/30/23 as a MA. -There was no documentation Staff F completed an LHPS competency Validation to perform urinary catheter care. Review of Resident #7's electronic medication administration record (eMAR) for May 2024 revealed: -Documentation that Staff F had performed catheter care on 05/06/24 during the evening, no time documented. -Documentation that Staff F had performed catheter care on 05/09/24 during the day, no time	D 161		

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D 161	Continued From page 5 documented. -Documentation that Staff E had performed catheter care on 05/13/24 during the day, no time documented. Interview with Resident #7 on 05/16/24 at 3:08pm revealed: -HH came by to visit him to make sure his catheter was in place but could not say how often. -The staff emptied the catheter bag daily. -He required assistance when bathing, and the staff washed around the catheter but did not push the skin back for cleanliness. Interview with a MA on 05/16/24 at 3:00pm revealed: -Resident #7 had an indwelling catheter and it was the PCA's and MA's responsibility to empty the catheter at night on 2nd shift and on 3rd shift. -It was the PCA responsibility to bath Resident #7. -To her knowledge all staff knew how to bathe Resident#7 with his indwelling catheter. -Any issues with Resident #7's catheter, she notified the HWD or the Health and Wellness Coordinator (HWC) on the C-side, and they notified Home Health. Interview with a PCA on 05/20/24 at 6:30pm revealed: -She gave Resident #7 sponge bath/wash up, and he would instruct her on how to go about washing him. -During his bath, she did not know that she was to clean the direct area around the catheter because no one trained her how or what to clean for Resident #7's near and around the catheter. -She worked with the facility for seven months and she was trained by the Health and Wellness Director (HWD) but did not recall catheter care	D 161		

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D 161	Continued From page 6 training. -She did not recall a training or a check off list for LHPS and did not know what LHPS meant. Interview with Staff F on 05/17/24 at 4:08pm revealed she had been trained and checked off on catheter care by the HWD in February of 2023. Interview with the HWD on 05/20/24 at 5:17pm revealed: -If a resident had a urinary catheter, she was responsible for completing the LHPS task form. -After she completed the LHPS task form, she would need to figure out who managed the resident's urinary catheter. -She checked off PCAs and MAs if a resident had a urinary catheter. -PCAs were trained to empty a urinary catheter bag, and MAs were trained to provide personal care around the catheter to keep it clean. -She trained the PCAs and MAs to provide urinary catheter care, after she trained staff on the urinary catheter care she checked them off on the LHPS task list. Refer to interview with the HWD on 05/20/24 at 5:17pm. Refer to interview with the Administrator on 05/20/24 at 7:05pm. 2. Review of Resident #1's current FL2 dated 04/23/24 revealed: -Diagnoses included acute respiratory acidosis, paroxysmal atrial fibrillation, atrial fibrillation with rapid ventricular response, leukocytosis, acute alteration in mental status. -The resident was constantly disoriented. -The resident was non-ambulatory.	D 161			

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D 161	Continued From page 7 -The resident needed assistance with bathing, dressing, and total care. -The resident's current level of care was Assisted Living. Review of Resident #1's Care Plan dated 04/11/24 revealed: -The resident required physical assistance to and from the dining room and/or community activities as needed. -Physical impairment was one of the reasons for the escort assistance. -The resident used a walker and a manual wheelchair as a mobility aid. Review of Resident #1's Hospice/Facility Coordinated Task Plan of Care review dated 02/07/24 revealed: -The Hospice nurse visited with Resident #1 2 times a week. -Durable Medical Equipment provided was a walker and a wheelchair. Review of Staff C's personnel record revealed: -Staff C was hired on 12/28/22 as a personal care aide (PCA). -There was no documentation Staff C completed an LHPS competency Validation to perform transferring, semi-ambulatory or non-ambulatory residents. Review of Staff E's personnel record revealed: -Staff E was hired on 08/30/23 as a medication aide (MA). -There was no documentation Staff E completed an LHPS competency Validation to perform transferring assistance with or ambulation with assistive device for semi-ambulatory or non-ambulatory residents.	D 161		

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D 161	Continued From page 8 Review of Staff F's personnel record revealed: -Staff F was hired on 08/30/23 as a MA. -There was no documentation Staff E completed an LHPs competency Validation to perform transferring assistance with or ambulation with assistive device for semi-ambulatory or non-ambulatory residents. Interview with Staff F on 05/17/24 at 4:08pm revealed she had been trained and checked off the staff competency validation for LHPs tasks by the HWD in February of 2023. Refer to interview with the Health and Wellness Director (HWD) on 05/20/24 at 5:17pm. Refer to interview with the Administrator on 05/20/24 at 7:05pm. _____ Interview with the Health and Wellness Director (HWD) on 05/20/24 at 5:17pm revealed: -A resident was evaluated for LHPs tasks prior to admission and after the resident was admitted within 14 to 30 days after admission. -Prior to admission she would complete a personal care assessment on a resident at their home, a hospital, or a skilled nursing facility. -After the resident was admitted to the facility, she would complete the personal care assessment again. -She would complete a resident's Care Plan with information obtained from a resident's personal care assessment. -Once the HWCs reviewed the paperwork, she reviewed the paperwork for any orders that required an LHPs task. -The Business Office Manager (BOM) kept track of which staff needed to have their LHPs checklist completed.	D 161		

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D 161	Continued From page 9 -It was her responsibility to complete staff competency validations for LHPS tasks by return demonstration. -She thought she had completed the competency validation for LHPS tasks for all clinical staff. -It was an oversight on her part that she did not complete the competency validation for LHPS tasks for Staff C, E, and F. Interview with the Administrator on 05/20/24 at 7:05pm revealed: -The HWD should have completed staff competency validations for LHPS tasks. -It was an oversight of the HWD to not complete staff competency validations for LHPS tasks by return demonstration. -He expected staff to be validated by return demonstration for LHPS tasks to ensure residents received the appropriate care.	D 161		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have	D 255		

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D 255	Continued From page 10 become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete an assessment and care plan for 1 of 7 sampled residents (#2) with significant change in mobility with repeated falls. The findings are: Review of Resident #2's current FL-2 dated 03/21/24 revealed: -Diagnoses included traumatic subdural	D 255		

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D 255	Continued From page 11 hematoma with loss of consciousness, atrial flutter, bradycardia, tachycardia, hypothyroidism, hyperlipidemia, breast cancer and depression. -The resident was documented as semi-ambulatory. -The resident required assistance with bathing and dressing. Review of the Resident Register for Resident #2 revealed there was no admission date listed. Review of Resident #2's Personal Service Plan (PSP) assessment signed by the Health and Wellness Director (HWD) and dated 12/23/23 revealed: -Below the Escort and Mobility heading, the resident was independent going to and from the dining room or community activities. -Be alert to heightened risk for falling. -The resident had fallen in the last 12 months. -The resident had fallen with admission to hospital. -The resident used a cane as a mobility aid. -The resident used a walker as a mobility aid. -The resident was independent with ambulation and used a cane and walker. -The resident was independent with transfers. 1. Review of Resident #2's Incident/Accident (I/A) report dated 03/02/24 revealed: -The incident time was documented as 1:00am. -The location of the incident was in the resident's bathroom, not the shower or tub. -The nature of the incident was fall/unwitnessed. -There was no apparent injury. -Initial action taken were vital signs recorded as BP 105/58, P 80, R 18, and T 97.6. -The resident's responsible party (RP) was contacted, and the nurse was notified. -The severity code was level 1 with no apparent	D 255		

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D 255	Continued From page 12 harm or injury. -The HWD was notified at 1:40am on 03/02/24. -Resident #2's RP was notified at 1:15am on 03/02/24. -The PCP was notified via fax at 1:45am on 03/02/24. -In the follow-up information section of the report, it was noted "no follow-up entries exist". -The I/A report was acknowledged and approved by the HWD on 03/07/24 at 9:38am. Review of Resident #2's electronic progress notes entered 03/02/24: -The progress note type was "alert charting note/post-fall initial" dated 03/02/24 at 1:46am, the resident was found on the floor in the kitchen area of her apartment. She hit her head on the floor. She had a red raised area on the back of her head. The resident was on blood thinners. The resident could not stand without assistance and was unable to walk. Spoke with her RP and explained that the resident needed to be sent to the emergency department (ED) for evaluation because of multiple falls and weakness. The resident's RP agreed and would meet the resident at the ED. -There was another progress note type "alert charting note/post-fall initial" dated 03/02/24 at 1:49am. -Witness/Encounter narrative: the resident's fall occurred on 03/02/24 at 1:00am, the fall was in the kitchen area of the resident's apartment, the fall was not near furniture. -There was no one witness to the fall. -The first person on the scene following the fall was the medication aide (MA). -The fall details were documented by the MA. -Resident narrative: the resident was trying to get to a chair to sit down, she said her head and back hurt.	D 255		

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D 255	Continued From page 13 -Observations for head injury and relevant action taken: there were signs of head injury, she had a red raised area on the back of her head and was sent to the ED. -Her vital signs were taken, BP 105/58, lying and left arm, P 83 and regular, R 18, and T 97.6. -Pain reported/observed: "I'm in pain", head and back pain. -Skin observation: there were signs of other skin injury as a result of the fall, red raised area on the back of her head. -Extremity observation (as compared to baseline: the resident was able to move all extremities compared to normal pre-fall baseline. -Healthcare Provider Notification, the primary care provider (PCP) was notified that the resident was sent out and to notify her when the resident returned to the facility. -Resident #2's responsible party was contacted, and she would meet the resident at the hospital. -EMS was contacted and the resident was transported to the hospital. -Additional notes, the resident fell in her apartment and hit her head on the floor. She had a raised red area on the back of her head. The resident was on blood thinners and was weak when standing and could not walk. Spoke with the resident's RP and she agreed to send the resident to the ED and would meet her there. The resident also complained of back pain. Review of Resident #2's Post Fall Evaluation dated 03/02/24 at 1:49am revealed: -The 1st person on the scene was the personal care aide (PCA). -The form was first documented by the MA. -The fall date and time was 03/02/24 at 1:00am. -The fall occurred in the kitchen area of the resident's apartment, not near the furniture. -The fall was unwitnessed.	D 255		

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D 255	Continued From page 14 -The resident permitted vital signs to be taken. -The vital signs were documented as BP 105/58, P 83 and regular, R 18, and T 97.6. -The resident said she was not ok and had pain in her back and head and rated her as 8 on a scale of 0-10 on 03/02/24 at 1:53am. -She said she was trying to get to a chair to sit down. -She was wearing slippers. -Her care plan included use of a walker for ambulation, and she was using her walker at the time of the fall. -There were physical signs of head injury with a red raised area on the back of her head and the resident was sent to the ED. -There were signs of skin injury with a red raised area on the back of her head. -She was able to move all extremities. -The PCP was contacted via telephone that resident was sent to the ED and to contact her when the resident returned to the facility. -Her RP was contacted by phone and would meet her at the ED. -EMS was contacted and the resident was transported to the ED. -Additional observations and notes, the resident fell with in her apartment and hit head on the floor. She had a raised red area on the back of her head. The resident was on blood thinners and was weak when standing and could not walk. Spoke with the resident's responsible party and she agreed to send the resident to the ED and would meet her there. The resident complained of back pain. -The post-fall evaluation was e-signed by the MA on 03/02/24. Review of Resident #2's hospital discharge summary dated 03/07/24 revealed: -The admission date was 03/02/24.	D 255		

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D 255	Continued From page 15 -The reason for admission was for a fall from standing position. -Discharge activity was walking with assistance. -The problem list included subdural hematoma, acute pain from trauma and fall from standing. -She was not to restart Eliquis (a medication used as a blood thinner) until the risks and benefits were discussed with her PCP. -History and Physical included the resident fell from standing and was on Eliquis and had a 3 mm Subdural hematoma on CT scan. -Eliquis was placed on hold and neurosurgeon was consulted. -The resident was admitted for monitoring and was somewhat somnolent the first night but had dramatic improvement of mental status by hospital day one with only mild intermittent confusion at night. She never required a repeat CT scan. A skilled nursing facility (SNF) was recommended. She had no complications and remained in the hospital pending SNF approval. -The CT scan of the brain on 03/02/24 revealed a stable falcine subdural hematoma with 2 mm thickness, no mass effect and chronic microvascular changes with atrophy, stable. Review of Resident #2's progress notes entered 03/26/24 to 03/28/24 revealed: -There was an entry labeled general progress note at 10:43am, the resident returned to the facility today via transport. -The writer and staff assisted resident with transferring to the wheelchair. -The resident was helped to her room by staff. -Medications were given to the MA. -The resident had no complaints at the time of arrival. -Staff will monitor her throughout her stay at the facility. -There were no alert charting or progress notes	D 255		

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D 255	Continued From page 16 on 03/26/24 on the 3pm-11pm shift. -There were no alert charting or progress notes on 03/27/24 on the 11pm-7am shift, 7am-3pm shift or the 3pm-11pm shift. -There was an entry on 03/28/24 at 3:56pm labeled general progress note that home health would come the following day to start care for the resident. -There was an entry on 03/28/24 at 10:23pm labeled progress note that the resident stayed in bed until dinner time, her RP came to visit her, and she was currently resting with no concerns from her previous fall. 2. Review of Resident #2's I/A report dated 04/11/24 revealed: -The incident time was documented as 2:10pm. -The location of the incident was in the resident's room, not bedside. -The nature of the incident was fall/unwitnessed. -There was no apparent injury. -Initial action taken were vital signs recorded as BP 127/69, P 63, R 16, and T 97.1. -The resident's responsible party (RP) was contacted, and the nurse was notified. -The severity code was level 3 with harm/injury with outside treatment. -The HWD was notified at 2:10pm on 04/11/24. -Resident #2's RP was notified at 2:15pm on 04/11/24. -The PCP was notified via fax at 2:15pm on 04/11/24. -In the follow-up information section of the report, it was noted "no follow-up entries exist". -The I/A report was acknowledged and approved by the HWD on 04/17/24 at 11:07am. Review of Resident #2's hospital after visit summary dated 04/11/24 revealed: -The reason for the visit was a fall.	D 255		

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D 255	Continued From page 17 -The diagnosis was a fall. -The CT scan showed resolution of the previous subdural hematoma. -There were no new injuries. -It was felt safe to discharge the resident back to the facility and to return if there were any mental status changes or concerns. Review of Resident #2's electronic progress notes entered 04/11/24 to 04/13/24 revealed: -The progress note type was "alert charting note/post-fall initial", dated 04/11/24 at 2:31pm, the resident hit her head on the way down her chest, head injury was an automatic send out. -Vital signs were documented as BP 127/69 and P 63. -The resident did not report pain. -The resident said she was going from wheelchair to chair and stumbled back and fell. -There was no post-fall evaluation provided for Resident #2's 04/11/24 fall. Interview with the HWC on 05/17/24 at 10:07am revealed: -After a fall or when a resident returned from the hospital, the residents were checked every 30 minutes for the first 4 hours then every hour for 48 hours, then back to every 2 hours and the MAs were to do alert charting on the progress notes each shift for 3 days. -Resident #2 was reminded to use her call pendant and to ask for help. -Resident #2 had been receiving PT and OT and used a wheelchair instead of a walker since she returned from the SNF in late March 2024. -Resident #2 was encouraged to call her assistance when transferring to and from her wheelchair. -She did not know why there was no alert charting for Resident #2 after the 04/11/24 fall.	D 255		

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D 255	Continued From page 18 3. Review of Resident #2's I/A report dated 04/28/24 revealed: -The incident time was documented as 9:00pm. -The location of the incident was in the resident's room, not bedside. -The nature of the incident was fall/unwitnessed. -There was no apparent injury. -Initial action taken were vital signs recorded as BP 114/73, P 77, R 17, and T 97.6. -The resident's responsible party (RP) was contacted, and the nurse was notified. -The severity code was level 1 with no apparent harm or injury. -The HWD was notified at 9:00pm on 04/28/24. -Resident #2's RP was notified at 9:10pm on 04/28/24. -The PCP was notified at 9:20am am on 04/29/24. -In the follow-up information section of the report, it was noted "no follow-up entries exist". -The I/A report was acknowledged and approved by the HWD on 05/0124 at 10:30am. Review of Resident #2's Post Fall Evaluation dated 04/28/24 at 10:26pm revealed: -The 1st person on the scene was the PCA. -The form was first documented by the MA. -The fall date and time was 04/28/24 at 9:00pm. -The fall occurred in the resident's living room by her recliner. -The fall was unwitnessed. -The resident permitted vital signs to be taken. -The vital signs were documented as BP 114/73 sitting left arm, P 77 and regular, R 17, and T 97.6. -The resident said she was ok and was not in pain with a pain level documented as 1 on a scale of 0-10 on 04/28/24 at 10:33pm. -She said she was trying to get into her	D 255		

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D 255	Continued From page 19 wheelchair, and it slipped out from under her. -She was wearing shoes. -The resident was using a wheelchair for ambulation. -There were no physical signs of head injury. -There were no signs of skin injury. -She was able to move all extremities. -The PCP was notified. -Her RP was contacted by phone. -EMS was not contacted. -There were no Additional observations and notes. -The post-fall evaluation was not signed. Review of Resident #2's primary care provider (PCP) visit note dated 04/29/24 revealed: -The resident's diagnoses included depression. -The resident reported a generalized weakness and was not walking since she returned from a skilled facility about 1 month ago. -She is currently wheelchair bound and continued to follow with physical therapy (PT) and occupational therapy (OT). -She continued to experience generalized weakness and reports she is not walking, with very minimal movement since she returned from a skilled facility about one month ago. -She was wheelchair bound at this time. Interview with a PCA on 05/17/24 at 12:03pm revealed: -Resident #2 used to use a walker but had been using a wheelchair since she returned from rehab in March 2024. -Resident #2 required some assistance with bathing. Interview with Resident #2 on 05/17/24 at 11:42am revealed: -She was not a morning person and was more	D 255		

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D 255	Continued From page 20 active at night. -She used to use a walker to ambulate but now used a wheelchair. -Staff helped her with bathing and checked on her throughout the day. -She sometimes called for staff to help her get into her wheelchair, but usually she could get in her wheelchair without assistance. -She went to the bathroom independently. -She thought she had some falls in the past but really did not remember. -She was currently receiving PT. Interview with the Resident Care Coordinator (RCC) on 05/17/24 at 11:22am revealed:. -She knew Resident #2 fell frequently and that the majority of her falls were on the second and third shift. -Resident #2 was a night person and was up and about in the evening and overnight. -Resident #2 required stand by assistance with bathing and dressing but could get up and down by herself. -Resident #2 had been encouraged to use her call pendant to call for help and was currently receiving PT and OT and now used a wheelchair for ambulation since she returned from rehab. Interview with the HWC on 05/17/24 at 10:07am revealed: -After a fall or when a resident returned from the hospital, the residents were checked every 30 minutes for the first 4 hours then every hour for 48 hours, then back to every 2 hours and the MAs were to do alert charting on the progress notes each shift for 3 days. -Resident #2 was reminded to use her call pendant and to ask for help. -Resident #2 had been receiving physical therapy and occupational therapy and used a wheelchair	D 255		

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D 255	Continued From page 21 instead of a walker since she returned from the SNF in late March 2024. Second Interview with the HWC for the B side on 05/17/24 at 10:54am revealed: -She knew Resident #2 had frequent falls and the interventions prior to her March 2024 hospitalization that she was aware of was to remind her to use her call pendant and to ask for help. -Since Resident #2 had returned from rehab in March 2024, she received PT, OT and used a wheelchair instead of a walker. Interview with the HWD on 05/20/24 at 6:21pm revealed: -She performed care plan assessments for the residents upon admission to the facility and reassessed and updated the care plan every six months. -She also performed care plan re-assessments after a significant health change and after a return from the hospital or a skilled facility. -She visited Resident #2 while she was at the skilled nursing facility to assess if she was able to return to the facility. -Resident #2 was ambulatory with a walker at the time she saw her at the skilled nursing facility therefore the resident's care plan was not changed. -She was not aware that Resident #2 solely used a wheelchair for ambulation now. -Had staff advised her that Resident #2 used a wheelchair now for ambulation, she would have updated her care plan, Interview with the Administrator on 05/20/24 at 7:05pm revealed: -Care plan assessments were done within 14-30 days of admission and were updated every six	D 255		

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D 255	Continued From page 22 months. -Care plans were to be updated when there was a change in the resident's condition, such as a change in activities of daily living or a change in the resident's needs. -If a resident's ambulatory status changed from using a walker to using a wheelchair, their care plan was to be updated. Attempted telephone interview with Resident #2's RP on 05/17/24 at 11:25am was unsuccessful. .	D 255		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 7 sampled residents (#2) who was on a blood thinner and had twelve unwitnessed falls in a 4-month period with 3 emergency room visits, one which resulted in a facial bone fracture and a hospital admission and admission to a skilled nursing facility in March 2024 for a subdural hematoma (a collection of blood between the covering of the brain and the surface of the	D 270		

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D 270	Continued From page 23 brain). The findings are: Review of the facility's Fall Management Policy revealed: -The policy was revised on 01/2024. -Under Policy Overview, residents have the potential to fall and therefore the facility has identified universal fall precautions applicable to residents. A fall risk evaluation is completed at the time of move in/admission or per state regulations. A witnessed or reported unwitnessed fall, with or without injury, is reported in the facility's incident reporting system. Residents who sustain a fall should have a post fall evaluation completed to consider possible interventions to reduce the risk for future. -The definition of a fall refers to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury. -Policy Detail outlined, the administrator is responsible for verifying that associates have completed the facilities fall management training course during orientation and should review annually thereafter. -A fall risk evaluation is completed at the time of move-in or per state regulation for assisted living. -Resident falls are noted in the resident record and entered into the facility's incident reporting system. -A post fall evaluation is to be completed after a resident fall, individualized interventions are considered, and the evaluation is a part of the resident's record. -When a fall occurs in assisted living (AL), assist the resident and provide first aid or call emergency services as indication and follow directions of the emergency services operator.	D 270		

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D 270	Continued From page 24 -Notify the Health and Wellness Director (HWD)/nurse/designee and Administrator. -Notify the resident's primary care provider (PCP) for evaluation, care, and treatment if indicated and document in the resident record. -Notify the resident's family/responsible party and document in the resident record. -Document the resident fall/injuries, resident response, and interventions taken in the progress notes (Alert charting notes). -The service plan is reviewed for potential fall interventions and updated as necessary. -Review the fall at the next stand-up meeting. -Discuss resident falls at the next collaborative care review meeting. Review of Resident #2's current FL-2 dated 03/21/24 revealed: -Diagnoses included traumatic subdural hematoma with loss of consciousness, atrial flutter (a condition in which the heart's upper chambers beat too quickly), and bradycardia (slower than expected heart beat). -The resident was documented as semi-ambulatory. -The resident required assistance with bathing and dressing. -The level of care was AL. Review of Resident #2's Resident Register revealed there was no admission date listed. Review of Resident #2's care plan signed by the HWD and dated 12/23/23 revealed: -The resident was independent going to and from the dining room or community activities. -The resident was identified as a fall. -She fell in the last 12 months. -She fell and required admission to the hospital. -She was independent with ambulation and used	D 270		

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D 270	Continued From page 25 a cane and walker. -She was independent with transfers. Review of Resident #2's electronic incident/accident (I/A) report dated 12/07/23 revealed: -The incident time was 10:30pm. -The location of the incident was Resident #2's room/apartment bedside. -The nature of the incident was an unwitnessed fall. -The type of injury was bruising, cut, laceration, face area, scrape/abrasion, skin tear. -Body parts injured were both eyes and nose. -Initial action taken were vital signs recorded as blood pressure (BP) 141/97, pulse (P) 52, respirations (R)17, temperature (T)) 96.5. -Emergency medical services (EMS) was contacted and Resident #2 was checked for injury. -The HWD, Resident #2's responsible party (RP) and Resident #2's PCP were notified at 10:30pm on 12/07/24. -The I/A report was acknowledged and approved by the Health and Wellness Coordinator (HWC) on 01/12/24 at 1:20pm. Review of Resident #2's emergency department (ED) after visit summary dated 12/07/23 revealed: -The diagnoses included head injury, fall, closed fracture of the zygomatic arch (also known as the cheekbone), and traumatic hematoma of the forehead. -Care instructions included: the bruising of your face will continue to go into your cheek, this is expected, use an ice pack and acetaminophen (acetaminophen is used to treat mild to moderate pain). -The computed tomography (CT) scan showed there was a mild fracture along the lateral portion	D 270		

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D 270	Continued From page 26 of the eye and will heal without surgery. Review of Resident #2's electronic progress notes entered 12/07/23 and 12/08/23 revealed: -The progress note type was "alert charting note/post-fall initial". -Witness/Encounter narrative: Resident #2 fell on 12/07/23 at 10:30am, in her bedroom, near the bed. -The first person on the scene following the fall was a personal care aide (PCA). -The fall details were documented by the medication aide (MA). -Resident narrative: Resident #2 said she "felt fine, not fine fine but fine". -Resident #2 reported she was not in pain. -There were no physical signs of head injury. -Resident #2's vital signs were blood pressure (BP) 141/97, sitting and left arm, pulse (P) 62 and regular, respirations (R) 17, temperature (T) 96.5 F. -There were signs of bruising, signs of skin tears and signs of other injury as area as a result of the fall, Resident #2 had lacerations on both eyes, both eyes were swollen and bruised, and she had a goose egg on the right side of her forehead. -Resident #2's healthcare provider was contacted about her fall and she was sent to the hospital by EMS. -On 12/08/23 at 9:04am, there was an entry, note type "general progress note", the resident came back from the hospital at 9:30am and staff were doing every 30 minutes checks. -There were no Alert Charting notes documented on 12/08/23 for the 3:00pm-11:00pm shift. -There were no Alert Charting notes documented on 12/09/23 for the 11:00pm to 7:00am shift, the 7:00am-3:00pm shift, or the 3:00pm to 11:00pm shift.	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
(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 270	Continued From page 27 Review of Resident #2's Post Fall Evaluation dated 12/07/23 at 11:21pm revealed: -Her care plan included use of a walker for ambulation, but she was not using her walker at the time of the fall. -There was no information about individualized interventions per the facility's fall policy. -The post-fall evaluation was e-signed by the HWC for the B side on 03/09/24. Interview with the HWC for the B-side on 05/17/24 at 10:04am revealed: -After a fall, the residents were checked every 30 minutes for the first 4 hours by either the PCAs or the MAs, then every hour for 48 hours, then back to every 2 hours, which included looking in on the residents to see if they needed anything. -The MAs were to do alert charting on the progress notes each shift for 3 days. -Resident #2 was reminded to use her call pendant and to ask for help. -She was not aware of any other interventions put in place after Resident #2's 12/07/23 fall. -There were no interventions documented aside from the initial every 30-minute checks. Review of Resident #2's electronic I/A report dated 12/21/23 revealed: -The incident time was 11:30am. -The location of the incident was Resident #2's room/apartment bedside. -The nature of the incident was an unwitnessed fall. -There was no apparent injury. -Initial action taken were vital signs recorded as BP 139/68, P 60, R 18, and T 98.2. -The HWD was notified at 12:15am on 12/22/23. -Resident #2's RP was notified at 12:30am on 12/22/23. -The PCP was notified via tele-med at 12:25am	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
(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 270	Continued From page 28 on 12/22/23. -The I/A report was acknowledged and approved by the HWC on 01/26/24 at 1:11pm. Review of Resident #2's electronic progress notes entered 12/21/23 through 12/24/23 revealed: -The progress note type was "alert charting note/post-fall initial" dated 12/22/23 at 12:28am by the HWC for the B side. -Witness/Encounter narrative: Resident #2's fall occurred on 12/21/23 at 11:30am in her bedroom near her bed and no one witnessed the fall. -The first person on the scene following the fall was the MA. -The fall details were documented by the MA. -Resident narrative: Resident #2 said she walked to her bed to put a pad on her bed and said she was okay and not hurt. -There were no physical signs of head injury or skin injury as a result of the fall. -Resident #2's vital signs were BP 139-68, sitting and left arm, P 60 and regular, R 18, and T 98.2 -Resident #2 said she was not in pain. -Resident #2's PCP was notified and advised the facility staff were to continue to monitor the resident. -Resident #2's RP was contacted. -On 12/22/23 at 12:33am there was an entry, note type "general progress note", the resident was walking sideways to bed to place a pad down, the resident lost her balance and sat down on the floor and there was no injury. -There were no Alert Charting notes documented on 12/22/23 for the 7:00am-3:00pm shift or the 3:00pm-11:00pm shift. -There were no Alert Charting notes documented on 12/23/23 for the 11:00pm to 7:00am shift, the 7:00am-3:00pm shift, or the 3:00pm to 11:00pm shift.	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
(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 270	Continued From page 29 -There were no Alert Charting notes documented on 12/24/23 for the 11:00pm-7:00am shift, the 7:00am-3:00pm shift or the 3:00pm to 11:00pm shift. -There were no post fall interventions documented for Resident #2. Review of Resident #2's Post Fall Evaluation dated 12/22/24 at 12:28am: -The resident said she was okay and was not hurt and rated her pain as a 0 on a scale of 0-10 on 12/22/23 at 12:30am. -There was no information about individualized interventions per the facility's fall policy. -The post-fall evaluation was e-signed by the HWC for the B side on 03/09/24. Interview with the HWC for the B side on 05/17/24 at 10:04am revealed: -Resident #2 was reminded to wear non-skid socks and to use her walker. -There were no new interventions documented. Review of Resident #2's electronic I/A report dated 01/15/24 revealed: -The incident time was 12:10am. -The location of the incident was Resident #2's bedroom. -The nature of the incident was an unwitnessed fall. -There was no apparent injury. -Resident #2's vital signs were recorded as BP 122/69, P 69, R 18, and T 97.8. -The HWD was notified at 12:20am on 01/15/24. -Resident #2's RP was notified at 12:15am on 01/15/24. -The PCP was notified via tele-med at 12:25am on 01/15/24. -The I/A report was acknowledged and approved by the HWC on 01/26/24 at 12:25pm	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
(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 270	Continued From page 30 Review of Resident #2's electronic progress notes entered 01/15/24 through 01/17/24 revealed: -The progress note type was "alert charting note/post-fall initial" dated 01/15/24 at 12:27am and was authored by MA and the HWC for the B side. -Resident #2 fell on 01/15/24 at 12:10am in front of the closet in her bedroom, the fall was near other furniture, between the closet in the bedroom and the dresser, no one witnessed the fall. -The first person on the scene following the fall was the PCA. -The fall details were documented by the MA. -Resident #2 said she was putting clothes in her clothes basket and said she was fine. -There were no physical signs of head injury or skin injury. -Her vital signs were taken, BP 122/69, sitting and left arm, P 69 and regular, R 18, and T 97.8 -The PCP was notified and advised the facility staff to continue to monitor the resident. -Resident #2's RP was contacted. -There were no Alert Charting notes documented on 01/15/24 for the 7:00am-3:00pm shift or the 3:00pm-11:00pm shift. -There were no Alert Charting notes documented on 01/16/24 for the 11:00pm to 7:00am shift, the 7:00am-3:00pm shift, or the 3:00pm to 11:00pm shift. -There were no Alert Charting notes documented on 01/17/24 for the 11:00pm-7:00am shift, the 7:00am-3:00pm shift or the 3:00pm to 11:00pm shift. -There were no post fall interventions documented for Resident #2. Review of Resident #2's Post Fall Evaluation dated 01/15/24 at 12:27am: -Her care plan included use of a walker for	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
(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 270	Continued From page 31 ambulation, and she was using her walker at the time of the fall. -There was no information about individualized interventions per the facility's fall policy. -The post-fall evaluation was e-signed by the MA on 01/15/24. Interview with the HWC for the B side on 05/17/24 at 10:05am revealed: -Resident #2 was reminded to use her call pendant and to ask for help. -She was not aware of any other interventions put in place after Resident #2's fall on 01/15/24. -There were no new interventions documented. Review of Resident #1's I/A report dated 01/23/24 revealed: -The incident time was documented as 11:45pm. -The location of the incident was Resident #2's bedroom. -The nature of the incident was an unwitnessed fall. -There was no apparent injury. -Resident #2' vital signs were recorded as BP 124/65, P 77, R 18, and T 98.0. -The HWD was notified at 11:50pm on 01/23/24. -Resident #2's RP was notified at 11:55pm on 01/23/24. -The PCP was notified via tele-med at 12:00am on 01/24/24. -The I/A report was acknowledged and approved by the HWD on 01/26/24 at 1:11pm. Review of Resident #2's electronic progress notes entered 01/23/24 through 01/26/24 revealed: -The progress note type was "alert charting note/post-fall initial" dated 01/24/24 at 12:02am and was authored by MA and the HWC for the B side. -Resident #2's fall occurred on 01/23/24 at	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
(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 270	Continued From page 32 11:45pm in her bedroom near the dresser, no one witnessed the fall. -The first person on the scene following the fall was the MA. -The fall details were documented by the MA. -Resident #2 was putting away some clothes and said she was ok and not hurt. -There were no physical signs of head injury or skin injury. -Her vital signs were taken, BP 124/68, sitting and left arm, P 77 and regular, R 18, and T 98.0. -The PCP was notified and advised facility staff to continue to monitor the resident for any changes. -Resident #2's responsible party was contacted. -There were no Alert Charting notes documented on 01/24/24 for the 7:00am-3:00pm shift or the 3:00pm-11:00pm shift. -There were no Alert Charting notes documented on 01/25/24 for the 11:00pm to 7:00am shift, the 7:00am-3:00pm shift, or the 3:00pm to 11:00pm shift. -There were no Alert Charting notes documented on 01/26/24 for the 11:00pm-7:00am shift, the 7:00am-3:00pm shift or the 3:00pm to 11:00pm shift. -There were no documented post fall interventions for Resident #2. A post fall evaluation was not provided for Resident #2's fall on 01/23/24. Interview with the HWC for the B side on 05/17/24 at 10:05am revealed: -Resident #2 was reminded to use her call pendant and to ask for help. -She was not aware of any other interventions put in place after Resident #2's fall on 01/23/24. -She did not know why there was not alert charting for Resident #2 after the 01/23/24 fall. -She was not sure why there was no post-fall	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
(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 270	Continued From page 33 evaluation for Resident #2's 01/23/24 fall. -There were no new interventions documented as implemented after Resident #2 fell on 01/23/24. Review of Resident #1's I/A report dated 01/27/24 revealed: -The incident time was documented as 11:10pm. -The location of the incident was Resident #2's bedroom but not at her bedside. -The nature of the incident was an unwitnessed fall. -There was no apparent injury. -Resident #2's vital signs were recorded as BP 138/65, P 64 R 18, and T 97.6. -The HWD was notified at 11:25pm on 01/27/24. -A message was left on Resident #2's RP's cell phone at 11:30pm on 01/27/24. -The PCP was notified via tele-med at 11:35pm on 01/27/24. -The I/A report was acknowledged and approved by the HWD on 02/04/24 at 10:51pm. Review of Resident #2's electronic progress notes entered 01/27/24 through 01/30/24 revealed: -The progress note type was "alert charting note/post-fall initial" dated 01/27/24 at 11:30pm and was authored by MA and the HWC for the B side. -Resident #2's fall occurred on 01/27/24 at 11:10pm in her bedroom, she was not near any furniture. -No one witnessed the fall. -The first person on the scene following the fall was the MA. -The fall details were documented by the MA. -Resident #2 was going to the bathroom and said she was ok. -There were no physical signs of head injury or skin injury. -Her vital signs were recorded as BP 138/65,	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
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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
D 270	Continued From page 34 sitting and left arm, P 64 and regular, R 18, and T 97.6. -The PCP was notified and advised facility staff to continue to monitor the resident for any changes. -Resident #2's responsible party was contacted. -There were no Alert Charting notes documented on 01/28/24 for the 11:00pm-7:00am shift, the 7:00am-3:00pm shift or the 3:00pm-11:00pm shift. -There were no Alert Charting notes documented on 01/29/24 for the 11:00pm to 7:00am shift, the 7:00am-3:00pm shift, or the 3:00pm to 11:00pm shift. -There were no Alert Charting notes documented on 01/30/24 for the 11:00pm-7:00am shift, the 7:00am-3:00pm shift or the 3:00pm to 11:00pm shift. -There were no post fall interventions documented for Resident #2. Review of Resident #2's Post Fall Evaluation dated 01/27/24 at 11:30pm revealed: -There was no information about individualized interventions per the facility's fall policy. -The post-fall evaluation was e-signed by the MA on 01/27/24. Interview with the HWC for the B side on 05/17/24 at 10:05am revealed: -She was not aware of any new interventions put in place after Resident #2's 01/27/24 fall. -She did not know why there was not alert charting for Resident #2 after the 01/27/24 fall. -She thought at some point physical therapy (PT) and occupational therapy (OT) were ordered for Resident #2 but was not sure when. -There were no new interventions documented. Review of Resident #2's I/A report dated 02/21/24 revealed:	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
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D 270	Continued From page 35 -The incident time was documented as 12:00am. -The location of the incident was in Resident #2's room at the bedside. -The nature of the incident was an unwitnessed fall. -There was no apparent injury. -Resident #2's vital signs were recorded as BP 123/69, P 69, R 18, and T 97.8. -The HWD was notified at 12:10am on 02/21/24. -Resident #2's RP was notified at 12:20am on 02/21/24. -The PCP was notified via tele-med at 12:15am on 02/21/24. -The I/A report was acknowledged and approved by the HWD on 03/07/24 at 10:09am. Review of Resident #2's electronic progress notes entered 02/21/24 through 02/23/24 revealed: -The progress note type was "alert charting note/post-fall initial" dated 02/21/24 at 12:20am and was authored by MA and the HWC for the B side. -Witness/Encounter narrative: Resident #2 fell on 02/21/24 at 12:00am beside her bed, -No one witnessed the fall. -The first person on the scene following the fall was the PCA. -The fall details were documented by the MA. -Resident #2 said she was fixing her bed and lost her balance and fell and said she felt okay. -There were no physical signs of head injury or skin injury. -Her vital signs were recorded as BP 123/69, sitting and left arm, P 69 and regular, R 18, and T 97.8. -The PCP was notified and advised the facility staff to continue to monitor the resident. -Resident #2's responsible party was contacted, and the RP did not want Resident #2 sent to the ED if she did not have any injuries.	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
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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
D 270	Continued From page 36 -There were no Alert Charting notes documented on 02/21/24 for the 7:00am-3:00pm shift or the 3:00pm-11:00pm shift. -There were no Alert Charting notes documented on 02/22/24 for the 11:00pm to 7:00am shift, the 7:00am-3:00pm shift, or the 3:00pm to 11:00pm shift. -There were no Alert Charting notes documented on 02/23/24 for the 11:00pm-7:00am shift, the 7:00am-3:00pm shift or the 3:00pm to 11:00pm shift. -There were no post fall interventions documented for Resident #2. Review of Resident #2's Post Fall Evaluation dated 02/21/24 at 12:20am revealed: -There was no information about individualized interventions per the facility's fall policy. -The post-fall evaluation was e-signed by the MA on 02/21/24. Interview with the HWC for the B side on 05/17/24 at 10:05am revealed: -Resident #2 was reminded to use her call pendant and to ask for help. -She was not aware of any other interventions put in place after Resident #2's fall on 02/21/24. -There were no new interventions documented. Review of Resident #2's I/A report dated 02/24/24 revealed: -The incident time was documented as 12:10am. -The location of the incident was in Resident #2's bathroom. -The nature of the incident was an unwitnessed fall. -The type of injury was a head injury, the body part injured was skull/scalp. -Resident #2's vital signs were recorded as BP 107/53, P 64, R 16, and T 97.1, EMS was called.	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
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D 270	Continued From page 37 -The HWD was notified at 12:15am on 02/24/24. -Resident #2's RP was notified at 12:20am on 02/24/24. -The PCP was notified via fax at 12:25am on 02/24/24. -The I/A report was acknowledged and approved by the HWD on 03/02/24 at 3:32pm. Review of Resident #2's ED after visit summary dated 02/24/24 revealed: -The reason for the visit was a fall. -The diagnosis was a fall. -Instructions: you were seen in the ED after a fall, the work-up was generally reassuring without any significant injuries found. You may expect to be achy and sore for the next few days. It is safe to take acetaminophen 1000mg every 6 hours as needed. Return to the ED if you have worsening symptoms which are concerning to you. -There were no injuries noted. There were no progress notes or alert charting notes provided for 02/24/24, 02/25/24 or 02/26/24. There was no post fall evaluation provided for Resident #2's 02/24/24 fall. Interview with the HWC for the B side on 05/17/24 at 10:06am revealed: -Resident #2 was reminded to use her call pendant and to ask for help. -She was not aware of any other interventions put in place after Resident #2's fall on 02/24/24. -She did not know why there was not alert charting for Resident #2 after the 02/24/24 fall and ED visit. -She did not know why there was not a post fall evaluation for Resident #2's 02/24/24 fall. -There were no new interventions documented.	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
(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 270	Continued From page 38 Review of Resident #2's I/A report dated 02/27/24 revealed: -The incident time was documented as 1:30am. -The location of the incident was in Resident #2's bathroom. -The nature of the incident was an unwitnessed fall. -There was no apparent injury. -Resident #2's vital signs were recorded as BP 132/62, P 68, R 20, and T 97.5. -The HWD was notified at 1:30am on 02/27/24. -Resident #2's RP was notified at 1:35am on 02/27/24. -The PCP was notified via fax at 1:35am on 02/27/24. -The I/A report was acknowledged and approved by the HWD on 03/02/24 at 3:33pm. Review of Resident #2's electronic progress notes entered 02/27/24 through 02/29/24 revealed: -The progress note type was "alert charting note/post-fall initial" dated 02/27/24 at 4:24am and was authored by MA. -Witness/Encounter narrative: Resident #2's fell on 02/27/24 at 1:30am in her bathroom near the toilet. -No one witnessed the fall. -The first person on the scene following the fall was the PCA. -The fall details were documented by the MA. -Resident #2 said she was washing her face and stepped back and fell back, she thought she hit her head on the wall but said she was not hurt. -The PCA and MA checked her head and both may have felt what could be a little knot. -The MA asked the resident if she was sore and the resident said, no I'm, I just fell back. -There were no vital signs documented.	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
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D 270	Continued From page 39 -There were no signs of skin injury as a result of the fall. -The PCP was notified via fax. -Resident #2's responsible party was contacted. -There were no Alert Charting notes documented on 02/27/24 for the 7:00am-3:00pm shift or the 3:00pm-11:00pm shift. -There were no Alert Charting notes documented on 02/28/24 for the 11:00pm to 7:00am shift, the 7:00am-3:00pm shift, or the 3:00pm to 11:00pm shift. -There was an entry on 02/29/24 at 6:41am documented as general progress note, the resident complained of weakness in legs and needed help to get to the bathroom and to bed, she said she could not stand. -There was an entry on 02/29/24 at 10:15pm documented as general progress note, no concerns at this time from previous weakness, the resident was ambulating by herself. -There were no post fall interventions documented for Resident #2. Review of Resident #2's Post Fall Evaluation dated 02/27/24 at 4:24am revealed: -There was no information about individualized interventions per the facility's fall policy. -The post-fall evaluation was e-signed by the MA on 02/27/24. Interview with the HWC for the B side on 05/17/24 at 10:05am revealed: -Resident #2 was reminded to use her call pendant and to ask for help. -She was not aware of any other interventions put in place after Resident #2's fall on 02/27/24. -She did not know why there was not alert charting for Resident #2 after the 02/27/24 fall until 02/29/24. -There were no new interventions documented.	D 270		

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D 270	Continued From page 40 Review of Resident #2's electronic progress notes entered 02/29/24 to 03/01/24 revealed: -The progress note type was "alert charting note/post-fall initial" dated 02/29/24 at 11:13pm and was authored by an MA and the HWC for the B side. -Resident#2's fall occurred on 02/29/24 at 10:55pm in her bathroom near the toilet. -No one witnessed the fall. -The first person on the scene following the fall was the PCA. -The fall details were documented by the MA. -Resident #2 said she was trying to get off of the toilet and said she "felt fine". -There were no physical signs of head injury or skin injury. -Resident #2's vital signs were recorded as BP 133/73, sitting and left arm, P 68 and regular, R 16, and T 97.8. -Resident #2's PCP was notified and the resident would be visited by the PCP the next time she was in the facility. -Additional notes, the MA entered Resident #2's room and found her sitting on her walker, two staff members were in the resident's room and had helped her off the floor. -The resident stated she hit her head. -The resident was informed that it was recommended to go to the ED if she hit her head. -The resident stated she did not want to go. -They called the resident's responsible party and she also refused to send the resident to the hospital. There were no other signs of injury. -There were no post fall interventions documented for Resident #2. -There were no alert charting notes on 03/01/24 for the 7:00am to 3:00pm shift. There was no I/A report provided for Resident	D 270		

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D 270	Continued From page 41 #2's 02/29/24 fall. There was no post fall evaluation provided for Resident #2's 02/29/24 fall. Interview with the HWC for the B side on 05/17/24 at 10:06am revealed: -Resident #2 was reminded to use her call pendant and to ask for help. -She was not aware of any other interventions put in place after Resident #2's fall on 02/29/24. -She did not know why there was no post- fall evaluation or I/A report for Resident #2's 02/29/24 fall. -There were no new interventions documented. Review of Resident #2's I/A report dated 03/02/24 revealed: -The incident time was documented as 1:00am. -The location of the incident was in Resident #2's apartment. -The nature of the incident was an unwitnessed fall. -There was no apparent injury. -Resident #2's vital signs were recorded as BP 105/58, P 80, R 18, and T 97.6. -The HWD was notified at 1:40am on 03/02/24. -Resident #2's RP was notified at 1:15am on 03/02/24. -The PCP was notified via fax at 1:45am on 03/02/24. -The I/A report was acknowledged and approved by the HWD on 03/07/24 at 9:38am. Review of Resident #2's electronic progress notes entered 03/02/24: -The progress note type was "alert charting note/ post-fall initial" dated 03/02/24 at 1:46am, Resident #2 was found on the floor in the kitchen area of her apartment.	D 270		

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D 270	Continued From page 42 -She hit her head on the floor. -She had a red raised area on the back of her head. -The resident was on blood thinners. -The resident could not stand without assistance and was unable to walk. - Resident #2's RP was contacted and advised that the resident needed to be sent to the ED for evaluation because of multiple falls and weakness. -The resident's RP agreed and would meet the resident at the ED. There was another progress note type "alert charting note/post-fall initial dated 03/02/24 at 1:49am. -Resident #2's fell on 03/02/24 at 1:00am, the fall was in the kitchen area of the resident's apartment, the fall was not near furniture. -There was no one witness to the fall. -The first person on the scene following the fall was the MA. -The fall details were documented by the MA. -Resident #2 said she was trying to get to a chair to sit down, she said her head and back hurt. -Resident #2 had signs of head injury, she had a red raised area on the back of her head and was sent to the ED. -Her vital signs were recorded as, BP 105/58, lying and left arm, P 83 and regular, R 18, and T 97.6. -Resident #2 reported pain in her head and back. -There were signs of skin injury as a result of the fall, red raised area on the back of her head. -Resident #2's PCP was notified that the resident was sent out and to notify her when the resident returned to the facility. -Resident #2's RP was contacted, and she would meet the resident at the hospital. Review of Resident #2's Post Fall Evaluation	D 270		

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D 270	Continued From page 43 dated 03/02/24 at 1:49am revealed the post-fall evaluation was e-signed by the MA on 03/02/24. Review of Resident #2's hospital discharge summary dated 03/07/24 revealed: -Resident #2 was admitted to the hospital on 03/02/24 with a subdural hematoma and acute pain from a fall. -Resident #2's discharge activity was walking with assistance. -The problem list included subdural hematoma, acute pain from trauma and fall from standing. -She was not to restart Eliquis (a medication used as a blood thinner) until the risks and benefits were discussed with her PCP. -History and Physical included the resident fell from standing and was on Eliquis and had a 3 mm Subdural hematoma on recent CT scan. -Placement at a skilled nursing facility (SNF) was recommended at discharge. -The CT scan of the brain on 03/02/24 revealed a stable falcine subdural hematoma (the falcine sinus is a normal structure within the brain, hematoma is a collection of blood) with 2 mm thickness. Review of Resident #2's progress notes entered 03/26/24 to 03/28/24 revealed: -There was an entry dated 03/26/24 labeled general progress note at 10:43am, Resident #2 returned to the facility today via transport. -Staff assisted resident with transferring to the wheelchair. -Staff would monitor her throughout her stay at the facility. -There were no alert charting or progress notes on 03/26/24 on the 3:00pm-1:00pm shift. -There were no alert charting or progress notes on 03/27/24 on the 11:00pm-7:00am shift, 7:00am-3:00pm shift or the 3:00pm-11:00pm	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
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D 270	Continued From page 44 shift. -There was an entry on 03/28/24 at 3:56pm that home health would come the following day to evaluate for PT and OT services. Review of Resident #2's I/A report dated 04/11/24 revealed: -The incident time was documented as 2:10pm. -The location of the incident was in Resident #2's apartment. -The nature of the incident was an unwitnessed fall. -There was no apparent injury. -Resident #2's vital signs were recorded as BP 127/69, P 63, R 16, and T 97.1. -The HWD was notified at 2:10pm on 04/11/24. -Resident #2's RP was notified at 2:15pm on 04/11/24. -The PCP was notified via fax at 2:15pm on 04/11/24. -The I/A report was acknowledged and approved by the HWD on 04/17/24 at 11:07am. Review of Resident #2's ED after visit summary dated 04/11/24 revealed: -The reason for the visit was a fall. -The diagnosis was a fall. -The CT scan showed resolution of the previous subdural hematoma. -There were no new injuries. Review of Resident #2's electronic progress notes entered 04/11/24 to 04/13/24 revealed: -The progress note type was "alert charting note/post-fall initial", dated 04/11/24 at 2:31pm, Resident #2 hit her head and a head injury was an automatic send out. -Resident #2's vital signs were documented as BP 127/69 and P63. -The resident did not report pain.	D 270		

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D 270	Continued From page 45 -Resident #2 said she was going from her wheelchair to the chair and stumbled back and fell. -There were no Alert Charting notes documented on 04/11/24 for the 3:00pm-11:00pm shift. -There were no Alert Charting notes documented on 04/12/24 for the 11:00pm to 7:00am shift, the 7:00am-3:00pm shift, or the 3:00pm to 11:00pm shift. -There were no Alert Charting notes documented on 04/13/24 for the 11:00pm to 7:00am shift, the 7:00am-3:00pm shift, or the 3:00pm to 11:00pm shift. -There was no post-fall evaluation provided for Resident #2's 04/11/24 fall. Interview with the HWC for the B side on 05/17/24 at 10:07am revealed: -Resident #2 had been receiving PT and OT and used a wheelchair instead of a walker since she returned from the SNF in late March 2024. -Resident #2 was encouraged to call for assistance when she transferred to and from her wheelchair. -She did not know why there was no alert charting for Resident #2 after the 04/11/24 fall. Review of Resident #2's I/A report dated 04/28/24 revealed: -The incident time was documented as 9:00pm. -The location of the incident was in Resident #2's apartment. -The nature of the incident was an unwitnessed fall. -There was no apparent injury. -Resident #2's vital signs were recorded as BP 114/73, P 77, R 17, and T 97.6. -The HWD was notified at 9:00pm on 04/28/24. -Resident #2's RP was notified at 9:10pm on	D 270		

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D 270	Continued From page 46 04/28/24. -The PCP was notified at 9:20am am on 04/29/24. -The I/A report was acknowledged and approved by the HWD on 05/01/24 at 10:30am. There were no alert charting or progress notes provided for Resident #2 for 04/28/24, 04/29/24 or 04/30/24. Review of Resident #2's Post Fall Evaluation dated 04/28/24 at 10:26pm revealed: -There was no information about individualized interventions per the facility's fall policy. -The post-fall evaluation was not signed. Interview with the HWC for the B side on 05/17/24 at 10:07am revealed: -Resident #2 had been receiving PT and OT and used a wheelchair instead of a walker since she returned from the SNF in late March 2024. -She did not know why there was no alert charting for Resident #2 after the 04/28/24 fall. Interview with a PCA on 05/17/24 at 12:03pm revealed: -The PCAs checked on the residents every 2 hours to see if they needed assistance, such as for toileting. -They did not document their rounds. -If a resident had a fall or returned from the hospital, they were to be checked every 30 minutes for the initial shift after fall or after they returned to the facility. -If a resident was on every 30 minute checks, this was communicated to the PCAs by the MA at shift report. -Every 30 minute checks meant you checked on the resident to see if they needed assistance. -Resident #2 used to use a walker but had been	D 270		

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D 270	Continued From page 47 using a wheelchair since she returned from rehab in March 2024. -Resident #2 was on every 2 hour checks. Interview with a second PCA on 05/18/24 at 3:30pm revealed: -The residents were to be checked on every 2 hours to see if they needed any assistance by either the PCAs or the MAs. -If a resident had a fall, they were to be checked every hour for the shift. -Resident #2 tried to do things herself and had to be reminded to call for help, especially getting in and out of bed. -Resident #2 was on every 2 hour checks. Interview with Resident #2 on 05/17/24 at 11:42am revealed: -She was not a morning person and was more active at night. -She used to use a walker to ambulate but now used a wheelchair. -Staff helped her with bathing and checked on her throughout the day. -She sometimes called for staff to help her get into her wheelchair, but usually she could get in her wheelchair without assistance. -She went to the bathroom independently. -She thought she had some falls in the past but really did not remember. -She was currently receiving PT. Interview with the Resident Care Coordinator (RCC) on 05/17/24 at 11:22am revealed: -The residents were to be checked by the PCAs or MAs every 2 hours. -If a resident had a fall or returned from the hospital, they were to be checked every 30 minutes for the 1st 4 hours then every 2 hours. -The resident checks included making sure the	D 270		

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D 270	Continued From page 48 residents were not trying to get up by themselves, assisting with toileting and bathing, dressing, and grooming. -The MAs were to communicate verbally with the PCAs if a resident required more frequent monitoring than every 2 hours. -There was nowhere for the PCAs to document their resident checks. -During the night shift, the PCAs were to make sure the residents were in bed and not trying to get up by themselves. -She knew Resident #2 fell frequently and that the majority of her falls were on the second and third shift. -Resident #2 was a night person and was up and about in the evening and overnight. -Resident #2 required stand by assistance with bathing and dressing but could get up and down by herself. -Resident #2 had been encouraged to use her call pendant to call for help. -Resident #2 was currently receiving PT and OT and now used a wheelchair for ambulation since she returned from rehab. -She felt the night staff should check on Resident #2 more frequently than every 2 hours but the residents would sometimes get upset with the night shift PCAs for waking them up on their rounds. Second interview with the HWC for the B side on 05/17/24 at 10:54am revealed: -She was hired as the B side HWC in February 2024. -The residents were to be checked every 2 hours by the PCAs for incontinent care, assistance with bathing, grooming, dressing and transfers. -After a resident fell, they were to be monitored every 30 minutes for the first 4 hours then every 1 hour for 48 hours by the PCAs.	D 270		

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D 270	Continued From page 49 -The MAs were to do alert charting, which meant to enter a progress note each shift for 3 days after a fall or after return from the hospital or another facility. -There was nowhere for the PCAs to document their resident checks. -After a resident fell, the MAs completed an I/A report and submitted it to her for review. -The MAs also completed a post-fall evaluation, and the post fall evaluation was entered into the facility's electronic charting system. -After the post-fall evaluation was completed by the MAs, she and/or the HWD were to review them to come up with post fall interventions. -She did not know where post fall interventions developed by the HWCs and HWD were documented. -Any interventions for the residents were communicated verbally to the MAs and the MAs communicated the interventions to the PCAs. -The MAs gave verbal report to the next shift and kept a notebook called a 24-hour sheet on the medication cart to alert the next shift of any changes with the residents. -She knew Resident #2 had frequent falls and the interventions prior to her March 2024 hospitalization was to remind her to use her call pendant and to ask for help. -Since Resident #2 had returned from rehab in March 2024, she received PT, OT and used a wheelchair instead of a walker. Interview with the HWD on 05/16/24 at 8:49am revealed: -The residents were to be monitored by the PCAs and/or MAs every 2 hours. -When a resident had a fall, returned from the hospital or another facility, or had an acute change in condition, they were to be under increased supervision.	D 270		

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D 270	Continued From page 50 -Increased supervision consisted of every 30-minute checks for 4 hours then every hour for 24 hours then back to every 2 hours. -The MAs were to do alert charting, entering a progress note in the resident's record each shift for 3 days after the fall or incident. -There was nowhere for the PCAs to document their resident rounds. -After a resident had a fall, the MAs completed an I/A report and a post fall evaluation. -The I/A reports and the post fall evaluations were reviewed by her or the HWC for severity level and interventions. -She, the RCC and the HWCs had a daily debriefing during the weekdays at 9:30am to discuss resident falls and concerns. -Any fall interventions were communicated verbally to the MAs and the MAs communicated verbally with the PCAs at shift report and the MAs kept a notebook on the medication cart to write new concerns for the residents for the next shift. -Fall interventions were not documented in the resident's progress notes. Second interview with the HWD on 05/20/24 at 6:21pm revealed: -She knew Resident #2 had frequent falls and she felt the facility and staff had done everything they could think of as far as interventions. -Interventions for Resident #2 included: medication reviews, footwear evaluations, tripping hazard evaluations, and signs placed in her room to remind her to use her call pendant to request assistance. -Resident #2 had previously been on Eliquis and knew that put her at greater risk for injury. -Resident #2 had been discussed with care managers and corporate managers frequently during "fall calls" due to her frequent falls. -Resident #2 received PT and OT since her	D 270		

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D 270	Continued From page 51 return from the SNF in late March 2024 and thought she had PT at some point prior to the March 2024 hospitalization. -Resident #2's PCP had been notified of each fall, but she had not contacted the PCP to request interventions. -Interventions should have been documented in Resident #2's progress notes after each fall. -Alert charting should have been done each shift for 3 days after each of Resident #2's falls. Interview with the Administrator on 05/20/24 at 7:09pm revealed: -After a resident had a fall, they were to have increased monitoring for the first 48 hours. -I/A reports and post-fall evaluations were to be performed after each incident so interventions could be put in place. -Interventions should be developed by the RCC, HWCs and HWD and communicated to staff to be put in place after each fall. -Post fall interventions included removing potential tripping obstacles, footwear evaluation, placing visual reminders in the resident's room to remind them to call for help, PT, OT, and medication reviews. -He expected interventions to be put in place and documented in the facility's electronic medical record. Interview with Resident #2's PCP on 05/17/24 at 3:43pm revealed: -Resident #2 was previously on Eliquis for atrial fibrillation and this put her at a greater risk of injury from falls due the potential for bleeding. -She knew Resident #2 had fallen frequently. -Most of Resident #2's falls occurred after business hours, so the on-call provider was notified. -Resident #2 received PT and OT currently as	D 270		

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D 270	Continued From page 52 ordered per her SNF discharge orders and she had ordered PT and OT for Resident #2 periodically in the past for falls. -The facility had not contacted her to request fall interventions. -She was not sure what additional interventions she could recommended. Attempted telephone interview with Resident #2's RP on 05/17/24 at 11:25am was unsuccessful. The facility failed to provide supervision for 1 of 7 sampled residents (#2), who was identified as a fall risk and was on an oral blood thinner, which put her at greater risk for bleeding, had 12 falls in a 4-month period which resulted in an ED visit for a facial bone fracture and a hospitalization for a bleeding on the brain. This failure resulted in a substantial risk for serious physical harm to the resident and constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 05/17/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 19, 2024.	D 270		
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: TYPE B VIOLATION	D 273		

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D 273	Continued From page 53 Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 7 sampled residents (Resident #2, #5) related to the facility's failure to notify the primary care provider (PCP) and endocrinologist regarding high fingerstick blood sugars (FSBS) (#5) and a mental health and psychotherapy referral as ordered by the PCP (#2). The findings are: 1. Review of Resident #5's current FL-2 dated 04/06/24 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, chronic kidney disease, hyperlipidemia and prostate cancer with metastasis to the bone. -There was an order for Humalog Insulin (Humalog is a fast-acting insulin to treat high blood glucose) inject subcutaneously (under the skin) four times per day per sliding scale: 151-200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-500 = 8 units and call the PCP. -There was an order to check blood sugars before meals and at bedtime. Review of Resident #5's Resident Register revealed he was admitted to the facility on 04/09/24. Review of a progress note from Resident #5's endocrinologist dated 04/22/24 revealed: -Would recommend the following: Humalog 4 units subcutaneously (subq) three times per day before meals (base coverage for meals), give prior to each meal. -Adjust the Humalog dose according to blood sugar reading before the meal with the following	D 273		

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D 273	Continued From page 54 sliding scale, if 70 or less, hold insulin, treat for low blood sugar and recheck in 15 minutes, 71-99 = half dose Humalog if eating full meal 2 units, 100-200 = usual dose 4 units, 201-250 = add 1 unit (4+5 = 5 units), 251-300 = add 2 units (4+2=6 units), 301-351 = add 3 units (4+3=7 units), 351-400 = add 4 units (4+4=8 units), if greater than 400 = add 5 units (4+5=9 units). Review of Resident #5's electronic Medication Administration Record (eMAR) for April 2024 revealed: -There was an entry for Humalog Insulin inject subcutaneously four times per day per sliding scale: 151-200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-500 = 8 units, and call the primary care provider (PCP). -The FSBS was documented as 351 or above on 22 occasions from 04/10/24 through 04/24/24. -There was a subsequent entry with a start date of 04/25/24 for Humalog Insulin inject subcutaneously for times per day per sliding scale: if 0-70 = hold insulin and treat for low blood glucose and recheck in 15 minutes, 71-99 = 2 units, 100-200 = 4 units, 201-250 = 05 units, 251-300 = 6 units, 301-350 = 7 units, 351-400 = 8 units, 401-600 = 9 units. -There were no parameters listed to contact the provider for high or low readings with the subsequent Humalog order with the 4/25/24 start date. Review of Resident #5's April 2024 progress notes revealed: -There was an entry on 04/20/24 at 6:14pm by the medication aide (MA) that the resident was given 8 units of Humalog and she tried to call Resident #5's endocrinologist and responsible party (RP). -There was an entry on 04/21/24 at 1:05am by a	D 273		

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D 273	Continued From page 55 2nd MA that the resident's FSBS was rechecked and came down to 361. -There was no other documentation that the resident's PCP or endocrinologist had been contacted for elevated FSBS. Interview with Resident #5 on 05/15/24 at 10:44am revealed: -He received insulin four times per day. -He knew his blood sugars had been elevated since he moved to the facility because staff reported the blood sugars to him. -He denied symptoms when his blood sugar was elevated and was not sure why his blood sugar was elevated. Interview with the MA on 05/16/24 at 3:50pm revealed: -When a resident's FSBS were entered into the eMAR, if there were given parameters and the FSBS was outside of the parameters, the eMAR gave a prompt to call the provider. -Resident #5's FSBS constantly ran high. -Resident #5's responsible party (RP) was aware of his elevated FSBS and had advised her and other staff not to worry about contacting the provider unless the FSBS were "really high" in the 500s and that is why the provider was not notified each time Resident #5's FSBS were 351 or above. -Resident #5's FSBS was in the 500s on 04/20/24 so she decided to call the endocrinologist but received the provider's answering service, since it was after hours, and was unable to speak with the provider. -She called Resident #5's RP and was told by his RP not to worry about Resident #5's FSBS unless they were in the high 500s and that the RP would contact the endocrinologist for new insulin orders. -Resident #5's RP was aware of his FSBS and	D 273			

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D 273	Continued From page 56 stayed in contact with his endocrinologist. -She attempted to call Resident #5's endocrinologist when his blood sugar was above 500 on 4/20/24. Interview with the Health and Wellness Coordinator (HWC) for the C-side on 05/16/24 at 4:01pm revealed: -When the MAs entered the FSBS into the eMAR, if the FSBS was outside of the written parameters, the eMAR prompted the MA to notify the resident's provider. -It was the MAs responsibility to contact the provider if prompted by the eMAR. -Communication with the provider should be documented in the resident's progress notes by the MAs and should be documented in the 24-hour communication log notebook on the medication cart. -She knew Resident #5's FSBS ran high, and he was followed by an endocrinologist out of town. -She and the MAs had contacted Resident #5's endocrinologist numerous times about his elevated blood sugars but had to leave messages on the nurse triage line. -She did not have the dates or documentation of the phone calls placed to Resident #5's endocrinologist. -Resident #5's RP was aware of his elevated FSBS and communicated with his endocrinologist through a patient portal and via phone. -She provided Resident #5's FSBS information to his RP and she relayed this information to the endocrinologist. Review of a progress note from Resident #5's endocrinologist dated 04/22/24 revealed: -Received contact information today for Resident #5's facility. -Notified by Resident #5's RP that his blood	D 273		

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D 273	Continued From page 57 sugars have been trending high in the 200s-400s. -The resident's RP sent a screen shot of a partial April 2024 eMAR and looked like he was not receiving scheduled mealtime insulin. -There was an order for Humalog 4 units subq three times per day before meals (base coverage for meals), give prior to each meal. -There was an order to adjust the Humalog dose according to blood sugar reading before the meal with the following sliding scale, if 70 or less, hold insulin, treat for low blood sugar and recheck in 15 minutes, 71-99 = half dose Humalog if eating full meal 2 units, 100-200 = usual dose 4 units, 201-250 = add 1 unit (4+5 = 5 units), 251-300 = add 2 units (4+2=6 units), 301-351 = add 3 units (4+3=7 units), 351-400 = add 4 units (4+4=8 units), if greater than 400 = add 5 units (4+5=9 units). -Please fax the eMAR and glucose logs (a fax number was provided) to her attention. -She needed to know what all his insulin doses were and what his blood sugar readings were in order to make further adjustments as needed. Telephone interview with Resident #5's endocrinologist on 05/16/24 at 2:52pm revealed: -Resident #5 was a type 1 diabetic and needed to be on long-acting insulin as well as the fast-acting sliding scale insulin to help stabilize his blood sugar levels throughout the day. -She had never been contacted by the facility regarding elevated blood sugars for Resident #5. -Resident #5's RP had contacted her about his elevated blood sugars, and she issued new sliding scale orders. -She faxed the new sliding scale orders to the attention of the named HWC for the C-side on 04/22/24 and requested Resident #5's eMAR and FSBs be sent faxed to her office, and she had not received the information back from the facility.	D 273		

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D 273	Continued From page 58 -It was concerning to her that that she had not received the requested eMAR and FSBS log for Resident #5, if the facility had sent the FSBS log and the April 2024 eMAR, she would have seen that Resident #5 had not received Insulin Glargine and would have placed orders for Insulin Glargine in addition to the fast-acting Humalog insulin to help stabilize his blood sugars -Uncontrolled blood sugars could have long term effects such as neuropathy, vision problems and diabetic ketoacidosis (diabetic ketoacidosis develops when the body can't make enough insulin, a hormone that helps sugar enter cells for energy, instead fat is broken down for energy. This can cause acids called ketones to build up in the blood to levels that can be life-threatening). Second Interview with the HWC for the C-side on 05/16/24 at 4:16pm revealed: -She provided Resident #5's eMAR and FSBS logs to Resident #5's RP for the endocrinologist on 04/15/24. -She was sure she sent the requested information from the 04/22/24 endocrinology note. -She later said she had not faxed Resident #5's eMAR and FSBS logs to the endocrinologist as requested in the 04/22/24 endocrine progress note. -She was not sure why she had not faxed the requested eMAR and FSBS to Resident #5's endocrinologist. Interview with the HWD on 05/20/24 at 7:00pm revealed: -Resident #5's RP was very involved in managing Resident #5's care. -She was aware that staff contacted Resident #5's RP regarding his elevated FSBS. -Staff should have contacted Resident #5's endocrinologist and PCP regarding elevated	D 273		

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D 273	Continued From page 59 FSBS. Interview with the Administrator on 05/20/24 at 7:11pm revealed: -Resident #5's PCP and endocrinologist should have been contacted by the MA regarding his elevated FSBS and all attempts to contact the providers should be documented by the MA. Interview with Resident #5's PCP on 05/16/24 at 3:14pm revealed: -She saw Resident #5 on 04/25/24 to establish care. -She knew Resident #5 had sliding scale insulin but was not aware that he should be on long-acting insulin as well and planned to contact his endocrinologist. -It was important for the facility to notify her of Resident #5's elevated blood sugars so she could adjust his insulin. -Uncontrolled elevated blood sugars could lead to diabetic ketoacidosis. 2. Review of Resident #2's current FL-2 dated 03/21/24 revealed: -Diagnoses included traumatic subdural hematoma (a collection of blood between the covering of the brain and the surface of the brain) with loss of consciousness, breast cancer and depression. -The resident was documented as semi-ambulatory. -The resident required assistance with bathing and dressing. -The resident's level of care was assisted living (AL). Review of the Resident Register for Resident #2 revealed there was no admission date listed.	D 273		

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D 273	Continued From page 60 Review of Resident #2's primary care provider (PCP) visit note dated 04/29/24 revealed: -The resident reported a generalized weakness and was not walking since she returned from a skilled facility about 1 month ago. -She was currently wheelchair bound and continued to follow with physical therapy (PT) and occupational therapy (OT). -Staff reported that the resident did not want to get out of bed most days. -The resident had experienced significant weight loss since January 2024, losing around 23 pounds. -The resident reported eating okay but appeared depressed. -Resident #2 was not concerned about her mood but staff noted she rarely left her room and did not always participate in activities like she used to. -Plan-awaiting psychiatric follow-up for further recommendations. -The PCP spoke with the facility staff regarding the referrals and to ensure consent was obtained and to make sure Resident #2 was on the mental health provider list to be seen. -She was wheelchair bound at this time. -An order was placed to consult psychiatric and psychotherapy services for evaluation and treatment of depression. Review of Resident #2's record on 05/17/24 revealed there were no notes from a mental health provider. Interview with the Health and Wellness Coordinator (HWC) on the B-side on 05/17/24 at 2:46pm revealed: -The Resident Care Coordinator (RCC) printed the office visit notes and order sheets for the HWC to review.	D 273		

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D 273	Continued From page 61 -She reviewed the order sheets only and filed the provider notes, without reviewing the provider progress or visit notes. -She was not aware that Resident #2 had a psychiatric and psychotherapy order. Interview with the Health and Wellness Director (HWD) on 5/17/24 at 10:34am revealed: -She thought Resident #2's RP did not agree to the psychiatric referral and refused to sign the consent. -She did not have documentation of a conversation with Resident #2's RP regarding referral for psychiatric services. Interview with the RCC on 05/17/24 at 10:42am revealed: -She and the two HWCs processed orders for the residents. -She knew that Resident #2's PCP ordered psychiatric services for her. -Resident #2's PCP sent the referral for psychiatric services since they were with the same contracted company. -Resident #2's RP agreed to the psychiatric services referral for Resident #2. -There was a consent for psychiatric services in Resident #2's record but it was signed in 2021 and she did not realize she needed a new consent. -She had not obtained an updated consent for Resident #2 to receive psychiatric services. -The facility's contracted psychiatric providers came every week. -Resident #2 had not been seen by psychiatric services. -There was no process to ensure resident referrals were followed through. Second interview with the HWD on 05/20/24	D 273		

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D 273	Continued From page 62 6:46pm revealed: -She thought Resident #2's RP had denied psychiatric services but did not have documentation of this. -The RCC and the two HWCs were responsible for processing orders and ensuring resident referrals were completed. -If Resident #2's RP agreed to the psychiatric services referral, the resident would need a new consent for services signed and faxed the facility's contracted psychiatric provider. -She expected referrals to be completed and followed through. -Any denial of services by the residents or the resident's RP should be documented in the resident's record and reported to the resident's PCP. Interview with the Administrator on 05/20/24 at 7:11pm revealed: -The RCC and the two HWCs were responsible for processing orders and referrals. -The facility should have obtained and faxed an updated consent for Resident #2 to receive psychiatric services. -If Resident #2 or the resident's RP denied or refused services, this should have been documented and the resident's PCP notified. -He expected referrals to be completed and followed through. Interview with Resident #2's PCP on 05/20/24 at 4:45pm revealed: -She ordered psychotherapy and psychiatric services for Resident #2 at her last office visit because the resident had a history of depression. -Resident #2 would have benefited from a psychotherapy and a psychiatric evaluation to help get her out of "the funk she had been in" since returning from the skilled nursing facility last	D 273		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
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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
D 273	Continued From page 63 month. -She notified the RCC of the need for a consent for psychiatric services. -She was not notified that Resident #2 had not received psychotherapy or psychiatric services. -She expected the facility to make the referral for Resident #2 for psychotherapy and psychiatric services. -She expected to be notified by the facility if there was a delay or denial of the psychiatric referrals for Resident #2. Attempted telephone interview with Resident #2's responsible party (RP) on 05/17/24 at 11:25am was unsuccessful. _____ The facility failed to meet the acute health care needs of a resident (#5) who was an insulin dependent diabetic with parameters to contact the provider for FSBS above 351, having 22 documented FSBS above 351, which put him at risk for diabetic ketoacidosis, with one documented attempt to contact the resident's provider and not sending requested eMAR and FSBS logs to the resident's provider, and a resident (#2) with a history of depression, which worsened after return from a skilled nursing facility not receiving psychotherapy and psychiatric services as ordered by her PCP. The facility's failure was detrimental to the residents' health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/20/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 04,	D 273		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/20/2024
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D 273	Continued From page 64 2024.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure quarterly licensed health professional support (LHPS) evaluations were completed for 3 of 7 sampled residents (#1, #5, and #7) to include LHPS tasks for medication administration through injections and collecting	D 280		

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D 280	Continued From page 65 and testing of fingerstick blood sugars (#5), positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter (#7), and ambulation with assistive devices that require physical assistance (#1). The findings are: Review of the facility's Licensed Health Professional Support (LHPS) applies to Assisted Living, Alzheimer's, and Dementia Care policy on 05/20/24 revealed: -Residents should be evaluated to determine the level of care and services needed or requested utilizing various systems and processes including resident specific physician/healthcare provider orders. -The evaluation will be used to determine the price for needed care and services or other requests by the resident and family/responsible party. -Once service needs are determined, specifics of the services required and or requested will be documented in the service plan. -A Registered Nurse (RN) should complete an evaluation prior to the resident's move into a community. -A sales and marketing representative may gather resident information and should communicate this information to the Health and Wellness Director (HWD) nurse. -The final resident evaluation should be completed by an RN at move-in, within 14-30 days after move-in, quarterly, and as soon as possible after a change in condition that results in altered care needs over a period of greater than two weeks. -The evaluation should be completed in the presence of the resident with their request and/or preference considered whenever possible.	D 280		

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D 280	Continued From page 66 -Additional potential information sources may include the resident's family as requested, legally responsible party, ombudsman, the physician plan of care, hospital, nursing home, and any other pertinent 3rd party provider of care such as home health, hospice, etc. -Evaluation results should be entered into the software program and the original forms signed by a community representative, and resident or responsible party, and the signed forms should be placed in the resident record. -Based on the evaluation, triggers may prompt further review by a nurse and/or District leadership of the resident's care and service needs. 1. Review of Resident #7's current FL2 dated 04/16/24 revealed: -Diagnoses included congestive heart failure, atrial fibrillation, peripheral arterial disease, and abnormal gait. -The resident was semi-ambulatory and ambulated with a standard walker and a manual wheelchair. -The resident had an order for an indwelling catheter and was continent of bowel. -The resident's current level of care was Assisted Living. Review of Resident #7's Resident Register revealed an admission date of 04/18/24. Review of Resident #7's Care Plan dated 04/18/24 revealed the resident required the genital area to be washed, hands were to be washed, and empty the catheter bag, as needed. Review of Resident #7's LHPS initial evaluation and quarterly review dated 05/14/24 revealed: -There were no LHPS tasks identified.	D 280		

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D 280	Continued From page 67 -There was an LHPS evaluation signed by the facility's Nurse and dated 05/14/24. Telephone interview with Resident #7 Nurse from the Urologist's on 05/20/24 at 3:18pm revealed: -An order for HH to visit the resident once a month and as needed to change his urinary catheter. -The catheter was replaced on 04/24/24. Review of Resident #7's Home Health (HH) progress notes revealed: -On 04/19/24 Resident #7's vital signs were within normal limits, the catheter was last changed on 04/15/24 and wound care provided with no issues. -On 04/24/24 HH performed wound care and assessed catheter site, new securement device placed, and line noted to be clamped in old device, some irritation and blood noted at insertion site due to line pulling, adjusted and corrected problem and report given to the HWD. Observations of Resident #7 on 05/16/24 at 3:08pm revealed: -He was sitting in his recliner in his apartment. -His catheter bag hung next to the recliner off the floor. Interview with Resident #7 on 05/16/24 at 3:08pm revealed: -He walked with assistance short distances but when he went to the bathroom or to the dining hall, the staff provided assistance because he did not walk alone. -HH came by to visit him to make sure his catheter was in place but could not say how often. -The staff emptied the catheter bag daily. -He required assistance when bathing, and the staff washed around the catheter but did not push	D 280		

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D 280	Continued From page 68 the skin back for cleanliness. Interview with a medication aide (MA) on 05/16/24 at 3:00pm revealed: -Resident #7 had an indwelling catheter and it was the personal care aide (PCA) and MA responsibility to empty the catheter at night on 2nd shift and on 3rd shift. -It was the personal care aide (PCA) responsibility to bath Resident #7. -To her knowledge all staff knew how to bathe Resident #7 with his indwelling catheter. -She did not know what LHPS meant and did not recall hearing the word LHPS during a training. -Any issues with Resident #7's catheter, she notified the Health and Wellness Director (HWD) or the Health and Wellness Coordinator (HWC) on the C-side, and they notified Home Health. Interview with a PCA on 05/20/24 at 6:30pm revealed: -She gave resident #7 sponge bath/wash up, and he would instruct her on how to go about washing him. -During his bath, she did not know that she was to clean the direct area around the catheter because no one trained her how or what to clean for Resident #7's near and around the catheter. -She worked with the facility for seven months and she was trained by the HWD but did not recall catheter care training. -She did not recall a training or a check off list for LHPS and did not know what LHPS meant. Interview with the Health and Wellness Director (HWD) on 05/20/24 at 5:16pm revealed: -She was responsible for completing the LHPS resident evaluation form when a resident had a urinary catheter. -On 05/17/24, during her 30-day reassessment,	D 280		

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D 280	Continued From page 69 she became aware that she did not list the tasks on the LHPS correctly for Resident #7. -She was not aware that staff were not cleaning the catheter properly and staff did not document personal care. -PCAs were trained to empty a urinary catheter bag. -PCAs and MAs were trained to provide personal care around the catheter to keep it clean. -She was responsible for training the PCAs and MAs to provide urinary catheter care, after she trained staff on the urinary catheter care she checked them off on the LHPS task list. -Her staff should know the phrase LHPS, and they knew what it meant because she trained them since she was hired. -When a resident was scheduled to be admitted to the facility, she performed the initial LHPS prior to admittance then on admission day, within 14 & 30 days after move-in, quarterly, and when a change in condition was triggered. -When a resident returned from the hospital or rehabilitation center, she would look for an order to see if any tasks were assigned. -She was responsible for ensuring LHPS evaluations were done quarterly if a resident had a task. Interview with the Administrator on 05/20/24 at 7:21pm revealed: -Resident #7 would have a task for his catheter and the task should be identified. -He was unaware there were no LHPS tasks identified for Resident #7. 2. Review of Resident #5's current FL-2 dated 04/06/24 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, chronic kidney disease, hyperlipidemia and prostate cancer with	D 280		

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D 280	Continued From page 70 metastasis to the bone. -There was an order for Humalog Insulin (Humalog is a fast-acting insulin to treat high blood glucose) inject subcutaneously (under the skin) four times per day per sliding scale: 151-200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-500 = 8 units and call the primary care provider (PCP). -There was an order to check blood sugars before meals and at bedtime. Review of Resident #5's Resident Register revealed he was admitted to the facility on 04/09/24. Review of a progress note from Resident #5's endocrinologist dated 04/22/24 revealed: -Would recommend the following: Humalog 4 units subcutaneously three times per day before meals (base coverage for meals), give prior to each meal. -Adjust dose according to blood sugar reading before the meal with the following sliding scale, if 70 or less, hold insulin, treat for low blood sugar and recheck in 15 minutes, 71-99 = half dose Humalog if eating full meal 2 units, 100-200 = usual dose 4 units, 201-250 = add 1 unit (4+5 = 5 units), 251-300 = add 2 units (4+2=6 units), 301-351 = add 3 units (4+3=7 units), 351-400 = add 4 units (4+4=8 units), if greater than 400 = add 5 units (4+5=9 units). Review of Resident #5's electronic Medication Administration Record (eMAR) for April 2024 revealed: -There was an entry for Humalog Insulin (Humalog is a fast-acting insulin to treat high blood glucose) inject subcutaneously (under the skin) four times per day per sliding scale: 151-200 = 0 units, 201-250 = 2 units, 251-300 = 4 units,	D 280		

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D 280	Continued From page 71 301-350 = 6 units, 351-500 = 8 units, and call MD -There was a subsequent entry with a start date of 04/25/24 for Humalog Insulin inject subcutaneously for times per day per sliding scale: if 0-70 = hold insulin and treat for low blood glucose and recheck in 15 minutes, 71-99 = 2 units, 100-200 = 4 units, 201-250 = 05 units, 251-300 = 6 units, 301-350 = 7 units, 351-400 = 8 units, 401-600 = 9 units. -Humalog Insulin was documented as administered on 84 occasions from 4:00pm 04/09/24 through 7:00pm on 04/30/24. -There were no parameters listed to contact the provider for high or low readings with the subsequent Humalog order with the 4/25/24 start date. -There were 85 documented FSBSs documented between 4:00pm on 04/09/24 through 7:00pm on 04/03/24. Review of Resident #5's May 2024 eMAR revealed: -There was an entry for Humalog Insulin inject subcutaneously for times per day per sliding scale: if 0-70 = hold insulin and treat for low blood glucose and recheck in 15 minutes, 71-99 = 2 units, 100-200 = 4 units, 201-250 = 05 units, 251-300 = 6 units, 301-350 = 7 units, 351-400 = 8 units, 401-600 = 9 units. -Humalog Insulin was documented as administered on 54 occasions from 7:00am on 05/01/24 through 11:00am on 05/14/24. -There were 54 FSBSs documented between 7:00am 05/01/24 and 11:00am 05/14/24. Review of Resident #5's Care Plan dated 04/09/24 revealed: -Resident #5 had insulin-dependent diabetes. -Perform blood sugar monitoring three or more times per day.	D 280		

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D 280	Continued From page 72 -Perform insulin injections and rotate injection sites. -Resident #5 received sliding scale insulin per doctor's orders. Review of Resident #5's LHPS Initial Evaluation and Quarterly Review of Residents dated 04/09/24 revealed: -The check box for medication administration through injection was not marked. -The check box for collecting and testing fingerstick blood samples was not marked. -No LHPS tasks were identified at the time of assessment was documented. -There was documentation to initiate plan of care and to reassess quarterly and as needed. -There were no tasks documented under the LHPS Care Task Provided section. -There was no documentation under Staff Competency Validated column. -The LHPS Initial and Quarterly Review of Residents form was signed by the HWD. Interview with Resident #5 on 05/15/24 at 10:44am revealed: -Staff obtained his FSBS checked four times per day. -Staff administered insulin injections four times per day. Interview with the HWD on 05/20/24 at 5:16pm revealed: -She knew Resident #5 was an insulin dependent diabetic who required insulin injections and finger stick blood sugars. -She performed a full physical assessment and a record review as part of her LHPS evaluation for Resident #5. -It was an oversight on her part that she did not identify tasks of medication administration	D 280		

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D 280	Continued From page 73 through injection and collecting and testing fingerstick blood samples for Resident #5 and that she should have identified these tasks. Interview with the Administrator on 05/20/24 at 7:21pm revealed: -Resident #5 would have tasks for insulin injections and finger stick blood sugars and the tasks should be identified. -He was unaware there were no LHPS tasks identified for Resident #5. Refer to the interview with the Administrator on 05/20/24 at 7:21pm. 3. Review of Resident #1's current FL2 dated 04/23/24 revealed: -Diagnoses included acute respiratory acidosis, paroxysmal atrial fibrillation, atrial fibrillation with rapid ventricular response, leukocytosis, acute alteration in mental status. -Resident #1 was constantly disoriented. - Resident #1 was non-ambulatory. - Resident #1 was incontinent of bladder. - Resident #1 bowel continent status was not indicated. -The resident's current level of care was Assisted Living. Review of Resident #1's Resident Register revealed an admission date of 02/29/20. Review of Resident #1's Care Plan dated 04/11/24 revealed: -The resident required physical assistance to and from the dining room and/or community activities as needed. -Physical impairment was one of the reasons for the escort assistance. -The resident used a walker and a manual	D 280		

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D 280	Continued From page 74 wheelchair as a mobility aid. Review of Resident #1's LHPS initial evaluation & quarterly review revealed: -The LHPS was signed by the HWD and dated 10/03/22. -There were no LHPS tasks identified. -There were no other LHPS evaluations in Resident #1's record. Review of Resident #1's Hospice/Facility Coordinated Task Plan of Care review dated 02/07/24 revealed hospice provided a walker and a wheelchair for Resident #1. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable. Interview with the HWD on 05/20/24 at 5:16pm revealed: -She was not aware that she did not identify the tasks on the LHPS for Resident #1. -Resident #1 transferred well and she was unaware that an LHPS task for ambulation requiring physical assistance was needed. -She was not aware of the need for an assistive devices requiring physical assistance meant it was a task that needed to be addressed on the LHPS. Interview with the Administrator on 05/20/24 at 7:21pm revealed: -Resident #1 should have a task identified for her wheelchair assistance. -He was unaware there were no LHPS tasks identified for Resident #1. Attempted telephone interview with Resident #1's Home Health nurse on 05/20/24 at 5:06pm was	D 280		

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D 280	Continued From page 75 unsuccessful. Interview with the Administrator on 05/20/24 at 7:21pm revealed: - The LHPS required a physical assessment, and LHPS tasks should be written to match the care plan and signed off by the nurse. -The LHPS evaluations were done by the HWD or the HWC on the C-side if needed. -All personal care staff should have LHPS validation and should be checked off to ensure staff knew how to do the personal care properly. The facility failed to ensure licensed health professional support evaluations were completed and executed for 3 of 7 sampled residents. Resident #7 did not receive appropriate hygiene for his catheter during his baths and staff were not trained on how to take care of his catheter. Resident #5, an insulin-dependant diabetic, did not have identified LHPS tasks for collecting and testing fingerstick blood samples and medication administration through injections. Resident #1 did not receive any tasks for her activities of daily living in which she required physical assistance with ambulation. This failure was detrimental to the health, safety and welfare of all residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/20/24 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 4, 2024.	D 280		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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D 310	Continued From page 76 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that all therapeutic diet shall be served as ordered for 1 of 7 sampled residents (#7) who were on a texture modified diet. The findings are: Review of the Facility's diet manual dated 04/01/21 pages 39, 40, and 41 revealed: -The texture modified diet was approved as the facility's standardized diet. -The manual overview/use were the texture modified diet was appropriate for the older adult with mild oral and/or pharyngeal dysphasia. -The texture modified diet was consistent with the National Dysphagia Advanced Consistency diet and the purpose of the texture modified diet was to offer food that was moist and soft solid. -All meats and poultry were ground with the exception being small tender pieces of meat allowed in soups. -The texture modified diet may need to be individualized for the older adult who may have poor intake and/or increased needs. -Foods to avoid were dry, tough meats, and meats and poultry that was not ground. Review of Resident #7's current FL2 dated 04/16/24 revealed: -Diagnoses included congestive heart failure, atrial fibrillation, peripheral arterial disease, and	D 310		

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D 310	Continued From page 77 abnormal gait. -Diet order status was not indicated. -The resident's current level of care was Assisted Living. Review of Resident #7's Resident Register revealed an admission date of 04/18/24. Review of Resident #7's Care Plan dated 04/18/24 revealed: -Meal portions were large and no known food allergies. -Diet order status was not indicated. Review of Resident #7's Diet Order dated 05/08/24 revealed: -A texture modified diet. -The texture modified diet was the regular diet, modified to meat texture modified standards. -All meats and poultry were ground except for small tender pieces of meat allowed in soups. Observation of Resident #7 on 05/15/24 at 8:22am revealed: -Resident #7 was served grits, eggs, waffle, smoked sausage, water, and cranberry juice. -The waffle and smoked sausage were cut into bit size pieces. -He placed the smoked sausage in his mouth then spit it out. -He ate 100% of his grits, 85% of his eggs, 97% of his waffle, 0% of his smoked sausage, and he drank 5% of his water and 100% of his cranberry juice. Interview with Resident #7 on 05/15/24 at 8:26am revealed: -The food was good at the facility but sometimes he could eat the meat and sometimes he could not.	D 310		

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D 310	Continued From page 78 -It was hard to chew the smoked sausage pieces with no bottom teeth. -It was hard for him to chew meat without his dentures, and he did not put them in for breakfast. Observation of the regular diet menu for the lunch meal on 05/15/24 at 12:05pm revealed: -There was an entry for beef stew. -There was an entry for tomato basil salad. -There was an entry for lemon meringue pie -There was an entry for chilled peaches. -There was an entry for reduced sugar lemon pie. -There was an entry for Italian roasted chicken (always available). -There was an entry for baked whitefish with lemon (always available). -There was an entry for roast beef melt sandwich (always available). Observation of Resident #7 on 05/15/24 at 12:10pm revealed: -Resident #7 was served beef stew (grind), broccoli (grind), tomato basil salad, water, and tea. -He ate 100% of the beef stew, broccoli, tomato basil salad, and drank 100% of his water, and tea. Interview with Resident #7 on 05/15/24 at 12:30am revealed that lunch was good and that he could chew the food. Interview with a lead cook on 05/15/24 at 11:36am revealed: -Resident #7 had a texture modified diet which meant cut up meats "baby like pieces" or chopped and place gravy on it to moisten. -If Resident #7 food was ground, he would get upset and refuse to eat it.	D 310		

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D 310	Continued From page 79 -She spoke with the Health and Wellness Coordinator (HWC) about a week earlier about the resident's refusal to eat ground meat. Interview with a HWC on the on 05/15/24 at 4:26pm revealed: -She was not aware that dietary did not grind Resident #7's meats at each meal. -He did not usually wear his bottom dentures and was unsure of why he did not wear them. -She was not aware that he refused to eat the ground foods. -He had a previous order for pureed meats, and he refused the pureed. -Dietary did speak with her about the refusal of the pureed food but not about meats that needed to be grind. -She spoke with the primary care provider (PCP) to change the diet order to ground meats. -She expected dietary to follow the PCP diet order and if there were any issues to contact her so she could notify the PCP to see if special services were needed such as physical therapy or occupational therapy. -If the resident did not receive the proper diet order, he was at risk of aspirating, choking, and it could lead to malnutrition because he went hungry due to tired of complaining about his food. Interview with the Health and Wellness Director (HWD) on 05/20/24 at 5:16pm revealed: -She was not aware that dietary staff did not always grind Resident #7's meats. -She communicated with dietary about diet orders regularly and upper management helped in the dining hall with serving and watching the residents during meals. -Her expectations were for dietary staff to follow the diet orders, what the PCP recommended. -The dietary kitchen had a board on the wall with	D 310		

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D 310	Continued From page 80 the list of all diets including therapeutic diets with the resident's picture to assist with food preparation and guidance. -Prior to admission, she discussed the diet order and preference with the family and the resident, then she keyed this information in on the day of admission on the Care Plan. -The risk of not following the diet order was he could choke if his food was not ground. Interview with the Administrator on 05/20/24 at 7:35pm revealed: -He was not aware that dietary staff was not serving the appropriate diet order for Resident #7. -There was a diet order for a reason and dietary staff should follow the order. -If dietary staff was not following the order, it could be a choking hazard for the resident if not served correctly. -His expectations were dietary should follow what diet order the resident had and if the PCP changed the order, dietary must follow those orders. -There was an approved diet manual for guidance in the kitchen for all diet orders.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 7 sampled residents (#3) was treated with dignity and respect related	D 338		

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D 338	Continued From page 81 to a resident who felt rushed by staff to take her medications (#3). The findings are: Review of the facility's undated Declaration of Resident's Rights policy revealed every resident should have the right to be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. Review of Resident #3's current FL-2 dated 05/07/24 revealed: -Diagnoses included major depressive disorder, diabetes, hypertension, and chronic obstructive pulmonary disease (COPD). -The resident was semi-ambulatory. -There was no documentation of orientation status. -The current level of care was assisted living facility and the recommended level of care was skilled nursing facility. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 08/10/20. Review of Resident #3's Personal Service Plan (PSP) assessment dated 05/08/24 revealed: -The resident required physical assistance related to the inability to stand independently. -The resident required assistance with bathing and dressing. -The resident was not always oriented to place and time. -The resident demonstrated anxious, disruptive, or obsessive behaviors requiring additional attention from staff. -There were recommended interventions for staff to help decrease anxious, disruptive, or	D 338		

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D 338	Continued From page 82 obsessive behaviors. -Staff should approach the resident with a gentle voice and expression to tell the resident that she was safe and cared for by the staff. -Staff should use validation techniques and respond to emotions behind anxiety. -Staff should use a positive physical approach such as make eye contact with the resident and meet the resident on the same level she was on for example if the resident was in a seated position, staff should approach the resident in a seated position. -Staff should speak to the resident in a calm voice, respect and acknowledge the resident's reality and avoid attempts to argue or reason with the resident. Interview with Resident #3 on 05/14/24 at 9:51am revealed: -She had resided at the facility for approximately two years. -She had a difficult time taking several medications at once, she preferred to take 1 to 2 pills at a time because it was easier for her to swallow. -When the medication aides (MAs) brought her medications in the morning they reminded her that she needed to take her medications. -She explained to the MAs that she was slow taking her medications and it took her some time to take her medications. -She wanted to refuse her medications when she was rushed by one MA to take her medications. -When one MA rushed her to take her medications, she would try to explain to the MA that it took her time to take all her medications and she did not like to feel rushed. Interview with Resident #3 on 05/16/24 at 12:10pm revealed:	D 338		

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D 338	Continued From page 83 -She described one MA that rushed her when administering her medications in the morning. -She imitated how the MA would rush her to take her medications fast, and to "hurry up, I don't have time to wait for you to take one pill at a time." -She tried to explain to the MA that she needed to take her time when taking her medications because she felt she would choke if she tried to take more than 1 to 2 pills at a time. -She had reported to her family member her frustrations with the one MA that rushed her when she administered her medications. -The MA was not friendly to her and she felt the MA "just did not want to cooperate with her" when her medications were administered. -When the MA rushed her to take her medications it did not make her feel good, the MA made her feel frustrated. Telephone interview with Resident #3's family member on 05/14/24 at 3:57pm revealed: -The resident was uncomfortable with one MA because the MA rushed the resident to take her medication quickly. -The resident had reported to the family member several times that one MA rushed her to take her medications quickly and made the resident feel rushed. -The resident needed to take 1 to 2 pills at a time because it was easier for her to swallow only 1 to 2 pills at time instead of all her medications at once. -He had reported his concerns of the MA causing his family member to feel rushed when taking her medications to the Health and Wellness Coordinator (HWD) and the Administrator. -The family member had reported his concerns about the resident feeling rushed to take her medications to the Health and Wellness Director	D 338		

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D 338	Continued From page 84 (HWD) and Administrator a few times since January 2024. Telephone interview with Resident #3's family member on 05/16/24 at 10:23am revealed: -All MAs except for one MA took their time to administer the resident her medication and did not rush the resident. -He had observed most MAs give Resident #3 1 to 3 pills at time and wait a few minutes in between administering additional medication. -Resident #3 complained to him several times about one MA rushing her to take her medications and it frustrated the resident. Interview with a MA on 05/16/24 at 2:46pm revealed: -She administered medications to Resident #3 often. -She knew that Resident #3 needed extra time to take her medications because she preferred to take 1 to 2 pills at a time. -She was patient with Resident #3 and encouraged her to take her time when taking her medications. -She usually sat by the resident when she took her medications and held a cup of water for the resident, that the resident would take from her when she was ready to take more medications. -The resident had told her a few times that "another MA" frustrated her because she rushed her when taking her medications. -She had reported the residents' concern to the HWD but could not remember when. Interview with a second MA on 05/20/24 at 11:10am revealed: -When a resident did not want to take their medication, she would try to explain to them the importance of why they need to take the	D 338		

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D 338	Continued From page 85 medication. -She would offer to come back later and attempt to administer the medications. -The resident may be in a better mood when she came back to attempt to administer medications. -If a resident refused to take medication, she would go get another MA, the Resident Care Coordinator (RCC), the Health and Wellness Coordinator (HWC) or the HWD to see if they could get the resident to take their medication. -If she heard a staff person rushing the resident to take her medications, she would report it to the RCC, HWC, HWD or Administrator. Interview with the MA that Resident #3 reported rushed her at times on 05/20/24 at 11:15am revealed: -Sometimes Resident #3 refused to take her medication and she would have to come back to administer the resident's medications at the end of her medication pass. -She did not always have time to wait for the resident to take 1 to 2 pills during her medication pass. -She tried to encourage the resident to take her medications and the importance of her medications when she refused to take her medications. -Sometimes when the resident refused to take her morning medications, the MA would go get another staff person to administer the resident her medications because the resident got along better with a different staff person at times. Interview with the Resident Care Coordinator (RCC) on 05/16/24 at 3:15pm revealed: -She knew Resident #3 preferred to take only 1 to 2 medications at a time. -Resident #3 had never refused medications from her because she approached the resident in a	D 338		

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D 338	Continued From page 86 patient manner and did not rush the resident to take her medications. -Resident #3 was easily engaged when she sat with her to take her medications and the resident enjoyed joking with staff. -She was not aware that the resident was frustrated with a MA that rushed her to take her morning medications at times. -If the resident had reported feeling rushed by a MA to take her medications, she would report it to the HWD. Interview with the HWD on 05/15/24 at 4:57pm revealed: -Several MAs had come to her in recent months to report that Resident #3 refused her medications if staff did not administer her 1 to 2 pills at a time. -She directed the MAs to administer the resident's medications on the wing the resident resided on last to help the resident have more time to take her medications. -The resident would still refuse to take medications at times and was verbally aggressive with MAs. Second interview with the HWD on 05/20/24 at 6:38pm revealed: -She expected all staff to provide residents with respect and dignity because it was the resident's home. -Medication aides (MAs) should not rush residents to take their medications. -MAs should administer medications to all residents on an individual basis because each resident was different. -MAs should never rush a resident when administering medications. Interview with the Administrator on 05/15/24 at	D 338		

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D 338	Continued From page 87 5:16pm revealed: -Resident #3's family member had reported to him that one MA rushed the resident to take her medications. -The resident preferred to take her medications 1 to 2 pills at a time. -He communicated to the resident's family member that he would hold a training with all MAs to reinforce the importance of individualizing each resident's needs. -He held a training for all MAs at the facility near the end of March and focused on the importance of being patient with residents, and to recognize each resident was an individual and required different approaches for medication administration.	D 338		
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 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (#10, #11) observed during the medication pass including errors with a blood thinner and blood pressure medication and for 2 of 7 sampled	D 358		

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D 358	Continued From page 88 residents (#5, #6) pertaining to a long-acting insulin order and a blood pressure medication. The findings are: Review of the facility's medication policy dated 03/31/22 revealed: -Medication administration/assistance and or treatment shall be provided in a safe and timely manner, and as prescribed by the resident's physician/healthcare provider. -Medication assistance and administration should be in accordance with the prescriber's orders. -The Nurse or designee should supervise and direct associates who assist with medications. -The individual assisting and/or administering medications should verify the resident's identity before giving the resident his/her medications. -The individual assisting and or administering the medication should check the label three times to verify the right medication, right dosage, right time, and the right method of administration before giving the medication. The medication error rate was 7% as evidenced by 2 errors out of 27 opportunities during the 8:00am medication pass on 05/15/24. 1. Review of Resident #11's current FL-2 dated 04/10/24 revealed: -Diagnoses included atrial fibrillation, hypertension, hypothyroidism and mitral regurgitation with congestive heart failure. -There was an order for Eliquis 5mg, 1 tablet twice a day (Eliquis is a blood thinner used to prevent blood clots and strokes in people with atrial fibrillation and deep vein thrombosis). Review of Resident #11's primary care provider (PCP) triage noted dated 05/05/24 revealed:	D 358		

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D 358	Continued From page 89 -Discontinue Resident #11's Eliquis 5mg twice daily. -Decrease Resident #11's Eliquis dosage to 2.5mg twice daily. -Her electrocardiogram (EKG) showed unspecified atrial tachycardia, slightly abnormal rhythm. -The cardiologist stated only to discontinue Eliquis if the EKG showed normal sinus rhythm. Review of Resident #11's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Eliquis 5mg, take 1 tablet twice daily scheduled for 7:00am and 8:00pm with a discontinue date of 05/26/24. -Eliquis 5mg was documented as administered twice daily from 7:00am on 05/01/24 to 8:00pm on 05/06/24. -There was an entry for Eliquis 2.5mg, 1 tablet twice daily scheduled at 8:00am and 8:00pm with a start date of 05/06/24. -Eliquis 2.5mg was documented as administered twice daily from 8:00am on 05/07/24 to 8:00am on 05/15/24. Observation of the 8:00am medication pass on 05/15/24 revealed: -The medication aide (MA) prepared 9 tablets in a medication cup that included one Eliquis 5mg tablet for Resident #11. -The MA administered the 9 medications to Resident #11 at 7:50am with a cup of water. -The MA administered Eliquis 5mg tablet instead of Eliquis 2.5mg tablet. Observations of Resident #11's medications on hand on 05/15/24 at 10:54am revealed: -There were 2 bubble cards of Eliquis 5mg tablets, one bubble card with 3 tablets remaining	D 358		

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NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
(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 90 to take one tablet twice per day and the second bubble card with 28 tablets remaining to take one tablet twice per day. -The dispense date for the Eliquis 5mg was 05/03/24 for a quantity of 56 tablets. -There were 2 bubble cards of Eliquis 2.5mg tablets, one bubble card with 30 tablets remaining to take one twice per day and the second bubble card with 22 tablets remaining to take one twice day. -The dispense for the Eliquis 2.5mg was 05/06/24 for quantity of 52 tablets. Telephone interview with a representative with the facility's contracted pharmacy on 05/15/24 at 11:58am revealed: -Eliquis 5mg tablets dispensed on 05/01/24 for quantity of 56 to take twice daily for a 28 day supply. -A new order was received on 05/05/24 to discontinue Eliquis 5mg twice per day and to start Eliquis 2.5mg twice per day. -Eliquis 2.5mg was dispensed to the facility on 05/06/24 for a quantity of 52 for a 26 day supply. Second telephone interview with a representative with the facility's contracted pharmacy on 05/16/24 at 11:17am revealed the facility returned 31 tablets of Eliquis 5mg for Resident #11 the previous night (05/15/24). Interview with Resident #11 on 05/15/24 at 10:59am revealed: -She thought she had been on Eliquis for about 6 months but was not sure of the dosage or if the dose had changed. -She denied any problems with taking her medications. -She denied excessive bruising or bleeding with her medications.	D 358		

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D 358	Continued From page 91 Interview with the MA on 05/15/24 at 10:53am revealed: -The Resident Care Coordinator (RCC), the Health and Wellness Coordinators (HWCs) or the Health and Wellness Director (HWD) processed medication orders. -The RCC entered new orders into the eMAR once they were received from the provider and notified the MAs of the order change. -The night shift MA was responsible for medication cart audits, but she was not sure how often these were done. -The medication cart audit included making sure medications were on the medication cart, checking for expired medications, cleaning, tidying the medication cart and returning discontinued medications to the pharmacy. -She was taught to compare the eMAR with the medication label to make sure she had the correct medication and dosage for the resident. -She did not compare the medication label to the eMAR for Resident #11's Eliquis. -She was not aware that she had administered Eliquis 5mg to Resident #11 instead of Eliquis 2.5mg. -She was aware that the order had changed. -She was not sure who was responsible for removing the discontinued medication from the medication cart. -She should have paid closer attention to the eMAR and the medication label. Interview with the RCC on 05/15/24 12:07pm revealed: -New medication orders were sent to the pharmacy by PCP. -She or the HWCs put new orders in the eMAR system. -The MAs could put in orders, but she preferred	D 358		

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D 358	Continued From page 92 orders to be entered either by herself or the HWCs. -When a new order was entered, it was then reviewed and approved by one of the HWCs. -When there was a medication change, after the order was entered, she notified the MAs verbally and it was the MA's responsibility to remove the discontinued medication from the medication cart. -She notified the MA of the dosage change for Resident #11's Eliquis and the MA should have removed the Eliquis 5mg tablets from the medication cart to be returned to the pharmacy. -She did not know why the MA did not remove the Eliquis 5mg from the medication cart. -She was unsure how often medication cart audits were to be done but thought it may have been 3 or more weeks since a medication cart audit had been done. -There was no set schedule that she was aware of for medication cart audits. -The night shift MA put medications on the medication cart that came from the pharmacy overnight and removed discontinued medications from the medication cart. Interview with the HWC for the C-side (there were 2 HWC's, one covered the B-side of the facility and one covered the C-side of the facility) on 05/15/24 at 12:41pm revealed: -The MAs were to follow the facility's medication administration policy of the facility to verify: the resident's identity, the right medication, the right dosage and the right route and the right time when administering medication. -The MAs were to compare the medication label with the eMAR. -Medication cart audits were to be done weekly by the RCC but she was not aware if there was an assigned schedule. -The medication cart audit included looking for	D 358		

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D 358	Continued From page 93 expired medications, making sure medications were available, removing discontinued medications, cleaning, and organizing the medication cart. -Resident #11's Eliquis 5mg should have been removed from the medication cart by the RCC or the MA when then new order for Eliquis 2.5mg was received for Resident #11. Interview with the HWC for the B-side on 05/15/24 at 4:34pm revealed: -The RCC or the MAs could enter orders into the eMAR system, but the RCC mainly entered orders. -After new orders were entered by the RCC or MA, one of the HWCs reviewed and approved the orders. -If the HWCs or RCC entered new orders, they notified the MAs verbally of the new orders and the MA removed the discontinued medication from the medication cart. -Medication cart audits were to be done weekly by the RCC. -Medication cart audits included looking for expired and discontinued medications, making sure medications were available and labeled properly and cleaning and organizing the medication cart. -She thought the last medication cart audit was 2-3 weeks ago. -She expected the MA to compare the medication label with the eMAR before the medication was administered to the resident. Interview with the Health and Wellness Director (HWD) on 05/15/24 at 12:56pm revealed: -The MAs were to compare the medication label to the eMAR before the medication was administered to the resident. -The RCC or the HWCs entered orders, if the	D 358		

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D 358	Continued From page 94 RCC entered orders, the HWCs reviewed and approved the orders. -It was the responsibility of whoever entered the new Eliquis orders for Resident #11 to either remove the discontinued medication from the medication cart or to make sure the MA removed the discontinued medication from the medication cart. -Medication cart audits were to be done weekly by the RCC or the HWCs. -They had been behind on medication cart audits, and she thought the last medication cart audit was about 6 weeks ago. -Resident #11 should have received the correct dose of Eliquis. Interview with the Administrator on 05/15/24 at 1:15pm revealed: -He expected the MAs to compare the residents' medication label to the eMAR to ensure the correct medication and dosage were being administered. -The MAs were to check the medication label to the eMAR three times. -The MA, RCC or HWC that entered the new medication orders were responsible for removing the discontinued medication from the medication cart. -There were periodic medication cart audits. -The night shift MA did medication cart audits when medication batches were received from the pharmacy. -He expected the residents to receive the correct medications as ordered. Interview with Resident #11's PCP on 05/15/24 at 11:55am: -Resident #11 was on Eliquis for atrial fibrillation (atrial fibrillation is an irregular and often very rapid heart rhythm).	D 358		

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D 358	Continued From page 95 -Eliquis was a blood thinner. -It was concerning to her that Resident #11 was still receiving Eliquis 5mg instead of Eliquis 2.5mg. -Too much Eliquis could cause bleeding issues for Resident #11. -Resident #11 had a history of frequent falls and she was especially concerned that if Resident #11 fell and hit her head, Eliquis could cause bleeding issues such as a brain bleed. -She decreased Resident #11's Eliquis dose to lessen the chances of potential bleeding issues with her history of frequent falls. 2. Review of Resident #5's current FL-2 dated 04/06/24 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, chronic kidney disease, hyperlipidemia. -There was an order for Humalog Insulin (Humalog is a fast-acting insulin used to treat high blood glucose) inject subcutaneously (under the skin) four times per day per sliding scale: 151-200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-500 = 8 units, and call the primary care provider (PCP). -There was an order an order for Insulin Glargine (Glargine is a long-acting insulin used to treat high blood glucose) inject 10 units subcutaneously (subq) nightly, there was a line drawn through the Insulin Glargine order and it was initialed, but the initials were illegible Review of Resident #5's Resident Register revealed he was admitted to the facility on 04/09/24. a. Review of Resident #5's current FL-2 dated 04/06/24 revealed there was an order an order for Insulin Glargine (Glargine is a long-acting insulin	D 358		

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D 358	Continued From page 96 used to treat high blood glucose) inject 10 units subcutaneously nightly, there was a line drawn through the Insulin Glargine order and it was initialed, but the initials were illegible. Review of Resident #5's hospital discharge to outside facility summary medication list dated 04/09/24 and time stamped 9:12am revealed a medication list with an entry for Insulin Glargine inject 4 units subcutaneously at bedtime under the heading of "continue these medications which have been changed". Review of a medication list from Resident #5's endocrinologist dated 04/20/24 revealed there was an entry for Insulin Glargine inject 4 units subcutaneously at bedtime with a start date listed as 04/09/24. Telephone Interview with a representative from the facility's contracted pharmacy provider on 05/17/24 at 11:17am revealed: -An order was received on 04/06/24 for Resident #5 for Insulin Glargine, inject 10 units at bedtime. -Insulin Glargine, one pen containing 300 units was dispensed to the facility on 04/08/24 and 05/07/24. -The pharmacy had not received a discontinue order and the order was still active. -She said the facility could have entered a discontinue order for the Insulin Glargine on their end but the facility's software did not communicate with the pharmacy's software. Observation of Resident #5's medication on hand on 05/16/24 at 4:02pm revealed there was an unopened pen of Insulin Glargine with a fill date label of 04/08/24 and received date of 04/09/24. Review of Resident #5's electronic Medication	D 358		

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D 358	Continued From page 97 Administration Record (eMAR) for April 2024 revealed there was an entry for Insulin Glargine, inject 10 units subcutaneously at bedtime with a start date of 04/08/24 and a discontinue date of 04/09/24. Review of Resident #5's May 2024 eMAR revealed there was not an entry for Insulin Glargine. Interview with Resident #5 on 05/15/24 at 10:44am revealed: -He received insulin four times per day. -He was not sure what type of insulin he received. -He knew his blood sugars had been elevated since he moved to the facility because staff would report the blood sugars to him. -He could not tell when his blood sugar was elevated and was not sure why his blood sugar had been high. Interview with the Health and Wellness Coordinator (HWC) for the C-side on 05/16/24 at 4:01pm revealed: -She did not know who put a line through the Insulin Glargine order on Resident #5's FL2 form. -She had reviewed Resident #5's hospital discharge summary and the medication list provided which included Insulin Glargine. -She did not consider the provided medication list with the hospital discharge summary dated 04/09/24 to be physicians orders and she did not question the entry for Insulin Glargine. -She did not know who discontinued Resident #5's Insulin Glargine on the eMAR. -Resident #5's medication orders were entered from Resident #5's FL2 form. -She felt Resident #5's insulin orders had been clarified. -She did not contact Resident #5's	D 358		

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D 358	Continued From page 98 endocrinologist for clarification if he was to receive Insulin Glargine in addition to Humalog insulin. Interview with Resident #5's responsible party (RP) on 05/16/24 at 10:52am revealed: -Resident #5 had been on insulin for 20 years. -He saw an endocrinologist for the past 20 years and she stayed in touch with Resident #2's endocrinologist regarding his blood sugar. -Resident #5 was supposed to be on long-acting insulin at night and fast acting insulin four times a day to cover his carbohydrate intake per the sliding scale. -She was not aware that Resident #5 was not receiving Insulin Glargine Interview with Resident #5's endocrinologist on 05/16/24 at 2:52pm revealed: -Resident #5 was a type 1 diabetic and needed to be on long-acting insulin as well as the fast-acting sliding scale insulin to help stabilize his blood sugar levels throughout the day. -She was not aware that Resident #5 was not receiving Insulin Glargine and not receiving the Insulin Glargine contributed to his elevated blood sugars. -She had never been contacted by the facility to clarify if Resident #5 needed Insulin Glargine. -It was concerning to her that that she had not received the requested eMAR and FSBS log for Resident #5, if the facility had sent the FSBS log and the April 2024 eMAR, she would have seen that Resident #5 had not received Insulin Glargine and would have placed orders for Insulin Glargine in addition to the fast-acting Humalog insulin to help stabilize his blood sugars -Uncontrolled blood sugars could have long term effects such as neuropathy, vision problems and diabetic ketoacidosis (diabetic ketoacidosis)	D 358		

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D 358	Continued From page 99 develops when the body can't make enough insulin, a hormone that helps sugar enter cells for energy, instead fat is broken down for energy. This can cause acids called ketones to build up in the blood to levels that can be life-threatening). Interview with the Administrator on 05/20/24 at 7:11pm revealed: -Staff were expected to clarify and follow all orders. -Staff should have contacted Resident #5's endocrinologist to clarify if Resident #5 was to receive Insulin Glargine. -All provider contact should be documented. Interview with Resident #5's PCP on 05/16/24 at 3:14pm revealed: -She saw Resident #5 on 04/25/24 to establish care. -She would be taking over management of Resident #5's diabetes and insulin from his endocrinologist. -She knew Resident#5 had sliding scale insulin but was not aware that he should be on long-acting insulin as well and planned to contact his endocrinologist. -Uncontrolled elevated blood sugars could lead to diabetic ketoacidosis. b. Review of Resident #5's current FL-2 dated 04/06/24 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, chronic kidney disease, hyperlipidemia. -There was an order for Humalog Insulin (Humalog is a fast-acting insulin used to treat high blood glucose) inject subcutaneously (under the skin) four times per day per sliding scale: 151-200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-500 = 8 units, and	D 358		

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D 358	Continued From page 100 call the primary care provider (PCP). Review of Resident #5's electronic Medication Administration Record (eMAR) for April 2024 revealed: -There was an entry for Humalog Insulin inject subcutaneously four times per day per sliding scale: 151-200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-500 = 8 units, and call MD. -The FSBS was documented as 351 or above on 22 occasions from 04/10/24 through 04/24/24. -There was a subsequent entry with a start date of 04/25/24 for Humalog Insulin inject subcutaneously for times per day per sliding scale: if 0-70 = hold insulin and treat for low blood glucose and recheck in 15 minutes, 71-99 = 2 units, 100-200 = 4 units, 201-250 = 05 units, 251-300 = 6 units, 301-350 = 7 units, 351-400 = 8 units, 401-600 = 9 units. -There were no parameters listed to contact the provider for high or low readings with the subsequent Humalog order with the 4/25/24 start date. Review of Resident #5's May 2024 eMAR revealed: -There was an entry for Humalog Insulin inject subcutaneously for times per day per sliding scale: if 0-70 = hold insulin and treat for low blood glucose and recheck in 15 minutes, 71-99 = 2 units, 100-200 = 4 units, 201-250 = 05 units, 251-300 = 6 units, 301-350 = 7 units, 351-400 = 8 units, 401-600 = 9 units. -Resident #5's FSBSs were greater than 351 on 12 occasions from 05/01/24 to 05/14/24 requiring Humalog sliding scale insulin. Interview with Resident #5's RP on 05/16/24 at 10:52am revealed:	D 358		

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D 358	Continued From page 101 -Resident #5 had been on insulin for 20 years. -He saw an endocrinologist for the past 20 years and she stayed in touch with Resident #2's endocrinologist regarding his blood sugar. -The facility kept in contact with her about Resident #5's elevated blood sugars. -She monitored Resident #5's blood sugars and knew they had been high, and she contacted the endocrinologist for new sliding scale orders for the facility. . Review of a progress note from Resident #5's endocrinologist dated 04/22/24 revealed: -Received contact information today for Resident #2's facility. -Notified by Resident #5's RP that his blood sugars have been trending high in the 200s-400s. -The resident's RP sent a screen shot of a partial MAR and looked like he was not receiving scheduled mealtime insulin. -Would recommend the following: Humalog 4 units subq three times per day before meals (base coverage for meals), give prior to each meal. -Adjust dose according to blood sugar reading before the meal with the following sliding scale, if 70 or less, hold insulin, treat for low blood sugar and recheck in 15 minutes, 71-99 = half dose Humalog if eating full meal 2 units, 100-200 = usual dose 4 units, 201-250 = add 1 unit (4+5 = 5 units), 251-300 = add 2 units (4+2=6 units), 301-351 = add 3 units (4+3=7 units), 351-400 = add 4 units (4+4=8 units), if greater than 400 = add 5 units (4+5=9 units). -Please fax the eMAR and glucose logs (a fax number was provided) to my attention. -She needed to know what all his insulin doses were and what his blood sugar readings were in order to make further adjustments as needed.	D 358		

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D 358	Continued From page 102 Interview with Resident #5's endocrinologist on 05/16/24 at 2:52pm revealed: -She had never been contacted by the facility regarding elevated blood sugars for Resident #5. -Resident #5's RP had contacted her about his elevated blood sugars, and she issued new Humalog sliding scale orders. -She had faxed the new sliding scale orders to the attention of the named HWC on 04/22/2 and had requested Resident #5's eMAR and FSBSs be sent faxed to her office, and she had not received the information back from the facility. Interview with the HWC for the C-side on 05/16/24 at 4:16pm revealed: -She provided Resident #5's eMAR and FSBS logs to Resident #5's RP for the endocrinologist on 04/15/24. -She was sure she sent the requested information from the 04/22/24 endocrinology note. -She later said she had not faxed Resident #5's eMAR and FSBS logs to the endocrinologist as requested in the 04/22/24 endocrine progress note. -She was not sure why she had not faxed the requested eMAR and FSBS to Resident #5's endocrinologist Interview with the Administrator on 05/20/24 at 7:11pm revealed: -Staff were expected to follow all orders. -Resident #5's PCP and endocrinologist should have been contacted regarding his elevated FSBS and all attempts to contact the providers should be documented. Interview with Resident #5's PCP on 05/16/24 at 3:14pm revealed: -She saw Resident #5 on 04/25/24 to establish care.	D 358		

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NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
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D 358	Continued From page 103 -She would be taking over management of Resident #5's diabetes and insulin from his endocrinologist. -She had not been notified of Resident #5's elevated blood sugars. -She usually requested the facility to contact her if a resident's blood sugar is less than 70 or greater than 400. -It was important for the facility to notify her of Resident #5's elevated blood sugars so she could adjust his insulin. -Uncontrolled elevated blood sugars could lead to diabetic ketoacidosis. 3. Review of Resident #10's current FL2 dated 03/11/24 revealed diagnoses included mild cognitive impairment of unknown or uncertain etiology. Review of Resident #10's signed physicians order sheet dated 03/11/24 revealed: -There was an order for Losartan Potassium tablet 50mg (Losartan is used to treat high blood pressure) take one tablet one time a day for hypertension, hold if systolic blood pressure is less than 105. -There was an order for weekly blood pressure on Mondays. Review of Resident #10's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Losartan Potassium tablet 50mg take one tablet daily for hypertension, hold if systolic blood pressure is less than 105. -There was an entry for weekly blood pressure, one time per day on Mondays. Observation of the 8:00am medication pass on 05/15/24 revealed:	D 358		

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D 358	Continued From page 104 -The medication aide (MA) prepared 10 tablets in a medication cup that contained one Losartan Potassium 50mg tablet at 7:32am. -The MA administered the 10 medications to Resident #10 at 7:35am. -The MA did not check Resident #10's blood pressure prior to administering the Losartan Potassium 50mg. Interview with Resident #10 on 05/15/24 at 10:20am revealed: -No one checked her blood pressure this morning. -Staff checked her blood pressure once per week, sometimes more frequently but not daily. -She denied feeling dizzy, weak, or faint after her morning medications. Observation of Resident #10's medication on hand on 05/15/24 at 10:26am revealed: -There was a bubble package of Losartan Potassium 50mg tablets, dispensed on 05/03/24 for a quantity of 28 tablets. -There were 15 Losartan Potassium 50mg tablets remaining in the bubble package. -The bubble package was labeled Losartan Potassium 50mg take one tablet by mouth every day. -There were no blood pressure parameters on the bubble package of Losartan Potassium 50mg. Interview with the MA on 05/15/24 at 10:26am revealed: -Resident #10's blood pressure was checked weekly on Mondays. -Resident #10's blood pressure was last checked on 05/14/24. -Blood pressure checks for Resident #10 only popped up on the eMAR on Mondays. -She did not check Resident #10's blood pressure	D 358		

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D 358	Continued From page 105 prior to administering her medications this morning because it did not pop up on the eMAR. -She had not noticed the note to hold the Losartan if Resident #10's systolic blood pressure was less than 105. -Resident #10 used to get daily blood pressure checks but she thought that order changed a while back. -She checked Resident #10's blood pressure at 11:10am and the resident's blood pressure was 155/60. Interview with the Health and Wellness Coordinator (HWC) for the B-side on 05/15/24 at 12:41pm revealed: -The MAs should always check the medication label to the eMAR. -The MAs should be able to see the supplemental notes containing medication parameters on the eMAR. -The MA should review any supplemental notes on the eMAR for parameters. -Resident #10's blood pressure should have been checked prior to administering the Losartan. Interview with the Health and Wellness Director (HWD) on 05/15/24 at 12:56pm revealed: -The MAs should always compare the medication to the eMAR. -The MAs were expected to review the eMAR for supplemental notes such as medication parameters. -If any medications had blood pressure parameters for administering, then the blood pressure should be checked each time before administration of the medication. -Resident #10's blood pressure should have been checked prior to administration of the Losartan. Interview with the Administrator on 05/15/24 at	D 358		

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D 358	Continued From page 106 1:15pm revealed: -Medication administration parameters should show up on the eMAR. -He expected the MAs to follow the parameter instructions. Interview with Resident #10's primary care provider (PCP) on 05/15/24 at 11:55am revealed: -She prescribed Losartan for Resident #10 for hypertension. -Resident #10's blood pressure was stable. -If Resident #10's blood pressure had been below the given parameter, administering the Losartan could cause her blood pressure to drop too low, potentially causing weakness, dizziness or fainting. 4. Review of Resident #6's current FL-2 dated 04/29/24 revealed diagnoses included aspiration pneumonia, hypotension, septic shock (septic shock occurs when a bacterial infection causes low blood pressure, widening of blood vessels, and organ failure), and acute respiratory failure with hypoxia (hypoxia is low levels of oxygen in body tissues). Review of Resident #6's signed physician order dated 02/13/24 revealed an order for Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25mg, give 12.5mg one time a day for hypotension, hold if heart rate is less than 60 beats per minute (Metoprolol Succinate ER is used to treat high blood pressure). Review of Resident #6's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25mg, give 12.5mg one time a day for hypotension,	D 358		

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D 358	Continued From page 107 scheduled for 8:00am, hold if heart rate is less than 60 beats per minute (BPM), which is an individual's heart rate. -Metoprolol Succinate ER 12.5mg was documented as administered at 8:00am from 03/01/24 to 03/08/24, from 03/10/24 to 03/27/24, and on 03/29/24 with no documentation that the resident's heart rate was taken. Review of Resident #6's April 2024 eMAR revealed: -There was an entry for Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25mg, give 12.5mg one time a day for hypotension, scheduled for 8:00am, hold if heart rate is less than 60 BPM. -Metoprolol Succinate ER 12.5mg was documented as administered at 8:00am from 04/03/24 to 04/08/24, from 04/10/24 to 04/16/24, and on 04/30/24 with no documentation that the resident's heart rate was taken. Review of Resident #6's May 2024 eMAR revealed: -There was an entry for Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25mg, give 12.5mg one time a day for hypotension, scheduled for 8:00am, hold if heart rate is less than 60 BPM. -There was documentation that Metoprolol Succinate ER 12.5mg was documented as administered at 8:00am from 05/01/24 to 05/17/24 with no documentation that the resident's heart rate was taken. Interview with the HWD on 05/20/24 at 6:38pm revealed: -Resident #6 should have his Medication administered as ordered. -She expected MAs to administer medication as	D 358		

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D 358	Continued From page 108 ordered. Interview with the Administrator on 05/20/24 at 7:05pm revealed: -MAs should follow PCP orders as listed on the eMAR. -MAs should have checked Resident #6's heart rate prior to administering the resident Metoprolol Succinate ER. Attempted telephone interview with Resident #6's PCP on 05/17/24 at 9:50am was unsuccessful. The facility failed to ensure medications were administered as ordered which resulted in Resident #11 receiving the incorrect dosage of a blood thinner which put her at risk for bleeding, and Resident #5 not receiving long-acting insulin to help stabilize his elevated blood sugar. This failure was detrimental to the health and welfare of the residents and constitutes a Type B violation. The facility provided a plan of protection in accordance with G.S. 131-34 on 05/17/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 4, 2024.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the	D 366		

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D 366	Continued From page 109 medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the recording of medication administration occurred immediately following the administration of medications including observations of morning medications left in a resident's room (#12). The findings are: Review of the facility's medication policy dated 03/31/22 revealed: -Medication administration/assistance and or treatment shall be provided in a safe and timely manner, and as prescribed by the resident's physician/healthcare provider. -Medication assistance and administration should be in accordance with the prescribers' orders. -The Nurse or designee should supervise and direct associates who assist with medications. -The individual assisting and/or administering medications should verify the resident's identity before giving the resident his/her medications. -The individual assisting and or administering the medication should check the label three times to verify the right medication, right dosage, right time, and the right method of administration before giving the medication. -The individual assisting with the medication should observe the resident ingesting the medication prior to documenting the administration/assistance on the resident's electronic medication administration record (eMAR) and record it immediately after medication assistance.	D 366		

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D 366	Continued From page 110 Review of Resident #12's current FL-2 dated 05/01/24 revealed: -Diagnoses included type 2 diabetes mellitus, sick sinus syndrome, hyperlipidemia, hypertension, cardiomyopathy, vertigo, and supraventricular tachycardia. -She was semi-ambulatory. Review of Resident #12's Resident Register revealed she was admitted to the facility on 05/03/23. Review of Resident #12's facility record revealed she did not have self-administration orders. Observations of Resident #12's apartment during the initial tour of the facility on 05/14/24 at 11:23am revealed Resident #12 was standing in her room, holding a medication cup containing 2 white tablets and one yellow tablet. Interview with Resident #12 on 05/14/24 at 11:23am revealed: -The medication aides (MAs) were responsible for bringing her medication. -If she was in the bathroom when the MA came in with her medication, they told her through the door that they had her medications and would leave them for her. -It was hard for her to swallow all of her medications at one time, so she took a few at a time. -She was finishing taking her morning medications. -The facility had a new rule that they were to watch her take her medications. -Some of the MAs would stay and watch her take her medications.	D 366		

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D 366	Continued From page 111 Second interview with Resident #12 on 05/16/24 at 10:34am revealed: -She took 7 pills in the morning and 14 pills in the evening. -She always counted her pills. -It was hard for her to swallow so many pills at one time. -2 of the MAs always watched her take her medications. -There were others that would leave the medication cup with her. Interview with the MA on 05/15/24 at 10:53am revealed: -Medications were never to be left with a resident unless they had a self-administer order. -She always watched residents swallow their medications. -It was important to watch residents swallow their medications to ensure they received them. -If a resident was in the restroom, when she entered, she would either wait for the resident or come back to them. Interview with a second MA on 05/17/24 at 4:08pm revealed: -The MAs were always to observe the residents take their medication unless they had a self-administer order. -She always observed the residents take their medications, this was important to make sure that the resident took all of their medications. Interview with the Resident Care Coordinator (RCC) on 05/15/24 at 12:19pm revealed: -The MAs should always observe the residents take their medications unless they had a self-administer order. -Medications should not have been left with Resident #12	D 366			

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D 366	Continued From page 112 Interview with the Health and Wellness Coordinator (HWC) on 05/15/24 at 12:23pm revealed: -Medications were never to be left with a resident unless there was a self-administer order. -It was important for the MAs to observe the residents take their medication to ensure they took them all. Interview with the Health and Wellness Director on 05/20/24 at 6:46pm revealed: -She was not aware that MAs were not observing residents take their medications. -Medications were not to be left at the resident's bedside unless they had a self-administration assessment and physician's order. -It was important for the MAs to observe the residents take their medications because other residents could potentially come in and take unattended medications, the resident may not take all of the medications, or the resident could potentially choke on the medications. Interview with the Administrator on 05/20/24 at 7:09pm revealed: -The resident's FL2 should note if a resident could self-administer medications. -Medications were not to be left with a resident unless there was a self-administer order. -The MAs were to observe the residents take their medications. -If medications were left with the resident, the resident could possibly choke on the medications or not take the medications. Attempted telephone interview with Resident #12's primary care provider (PCP) on 05/16/24 12:08pm was unsuccessful.	D 366		

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D 378	Continued From page 113	D 378		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medications were safely secured from residents' access to the medication room which contained an unlocked refrigerator that contained medications and a rescue inhaler found on a bedside table in a resident's room. The findings are: Review of the facility's medication storage policy dated October 2018 revealed: -Medications and treatments should be stored in an organized manner under proper conditions of sanitation, temperature, moisture, and light in accordance with the manufacturer's instructions. -Medications and treatments stored by the facility should be stored in designated locations that must be locked when not in use or when unattended. -Medications requiring refrigeration should be stored in a refrigerator located in the drug room at the nurse's station or other secure location. 1. Observation of the facility's medication storage room on 05/15/24 from 7:20am to 7:26am	D 378		

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D 378	Continued From page 114 revealed: -The door to the medication storage room on the assisted living (AL) unit was opened and the entire medication storage room was visible from the hallway. -There was a placard on the door with "Please Keep Door Closed." -There was a placard on the wall to the right of the medication storage room with "Medication Room." -There were no staff observed in the medication storage room. -There was a small refrigerator on the left side of the medication storage room. -There was a side piece for the padlock that attached to secure and lock the small refrigerator. -There was a padlock on top of the refrigerator, there was no key in the padlock. -The refrigerator was accessible, unsecured, with no padlock on the side locking areas. Observation of the unlocked refrigerator on 05/15/24 at 7:27am revealed: -The refrigerator had one freezer shelf, two shelves, and one drawer. -There were 5 separate sections on the side of the refrigerator door. -The freezer shelf had six ice packs that were melted. -The first shelf of the refrigerator contained two blue prescription bags of Lantus Solostar (Lantus Solostar is a long acting insulin used to treat diabetes), each bag contained five Lantus Solostar pens. -There was an unopened box of Lantus Solostar insulin pens that had a quantity of five pens. -There was an unopened box of Novolog Flex Pens (Novolog is a fast acting insulin to improve blood sugar) that contained five insulin pens. -There was one blue prescription bag that	D 378		

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D 378	Continued From page 115 contained one Semglee Insulin Pen (Semglee is a long acting insulin used to treat diabetes). -There was a blue prescription bag that contained five Insulin Lispro Pens (Insulin Lispro is used to treat diabetes). -There was one unopened box of Mounjaro Kwik Pens that contained four pens (Mounjaro is a medication used to treat type 2 diabetes). -There was one box of Formoterol Fumarate Inhalation Solution 20mcg/2 mL vials that contained 15 individually wrapped vials (Formoterol Fumarate Inhalation Solution is used to treat wheezing, shortness of breath, and chest tightness caused by chronic obstructive pulmonary disease). -The second shelf of the refrigerator contained two unopened boxes of Trulicity pens that each contained four pens (Trulicity is a medication used to lower blood sugar levels). -There was one unopened box of Mounjaro Kwik Pens that contained four pens. -There was one unopened box of Insulin Glargine that contained five pens (Insulin Glargine is a long acting medication used to treat type 2 diabetes). -The bottom drawer of the refrigerator contained one unopened box of Trulicity which contained four pens and one unopened box of Insulin Glargine that contained five pens. -The refrigerator door had four separate sections, with two sections on the top level, and two sections on the second level. -The left section of the top portion of the refrigerator contained four unopened boxes of Latanoprost Solution 0.005% eye drops (Latanoprost is used to treat glaucoma). -The right section of the top portion of the refrigerator contained two unopened blue plastic bags that each contained one prescription bottle labeled with Aplisol Injectable 5TU/0.1mL in a 5	D 378		

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NAME OF PROVIDER OR SUPPLIER BROOKDALE COUNTRY DAY ROAD		STREET ADDRESS, CITY, STATE, ZIP CODE 380 COUNTRY DAY ROAD GOLDSBORO, NC 27530		
(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 378	Continued From page 116 mL multiple dose vial (Aplisol is a solution used to test for tuberculosis). -There was one opened box of Lantus Solostar that contained two pens. -The second section of the refrigerator door had two sections. -The left section below the top section of the refrigerator contained two Insulin Glargine pens. -The right section below the top section of the refrigerator contained one bottle of Mylanta that was approximately half full (Mylanta is used to treat a variety of stomach and intestinal problems). -There were four unopened boxes of Latanoprost eye drops (Latanoprost eye drops are used to treat glaucoma). Interview with the Resident Care Coordinator (RCC) on 05/15/24 at 7:52am revealed: -She was not aware that the medication storage room was accessible to residents. -She was not aware that the refrigerator in the medication storage room was not locked. -Medications in the refrigerator should be refrigerated because of the directions on the pharmacy packing to refrigerate the medications. Interview with the Health and Wellness Director (HWD) on 05/15/24 at 8:30am revealed: -The medication room was being used by staff as a break room because the medication storage room was in the process of being moved. -The medication storage room and the refrigerator that contained medications should have been locked. -Staff knew that the medication storage room should be locked. Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/17/24 at	D 378		

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D 378	Continued From page 117 4:27pm revealed resident's that were not prescribed medications that were in an unsecured refrigerator at the facility could have adverse reactions if they took the unsecured medication. Interview with the Administrator on 05/20/24 at 7:05pm revealed: -The medication storage room was in transition to become a clinic at the facility for residents. -Staff had been using the medication storage room as a break room during the transition. -The medication storage room should have been locked and the refrigerator should have been locked. 2. Review of Resident #3's current FL-2 dated 05/07/24 revealed: -Diagnoses included major depressive disorder, diabetes, hypertension, and chronic obstructive pulmonary disease (COPD). -There was no documentation of orientation status. -The current level of care was assisted living facility, and the recommended level of care was skilled nursing facility. Observation of Resident #3's room on 05/16/24 at 12:09pm revealed: -There was a Ventolin HFA inhaler on a table beside the resident's recliner (Ventolin HFA Inhaler is a rescue inhaler to treat wheezing and shortness of breath caused by breathing problems). -There was a counter on the back of the Ventolin HFA inhaler that showed 47 puffs were left in the inhaler. -The resident was sitting in her recliner which was beside the table where the rescue inhaler was located.	D 378		

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D 378	Continued From page 118 Interview with Resident #3 on 05/16/24 at 12:10pm revealed: -She kept her rescue inhaler on the table by her recliner or in her purse. -She used her rescue inhaler when she had shortness of breath. -She was not sure how long the rescue inhaler had been in her room. Interview with the Resident Care Coordinator (RCC) on 05/17/24 at 11:18am revealed: -Resident #3 should not have any medications in her room because she did not have an order to self administer any medications. -She was not aware that the resident had a rescue inhaler in her room. Interview with the Health and Wellness Coordinator (HWC) for the B side on the AL unit on 05/17/24 at 11:50am revealed: -Resident #3 did not have an order to self-administer medications and should not have any medications in her room. -Resident #3 was at risk of abusing the medication due to not knowing how many inhalations she should take of the inhaler. -If a resident had medications in their room, they needed to have an order to self-administer medications. Observation of the HWC for the B side on the AL unit on 05/17/24 at 12:07pm revealed: -She entered Resident #3's room and greeted the resident. -She asked the resident for any inhalers that she had in her room. -She explained to Resident #3 that her primary care physician (PCP) had not written an order for her to self-administer her inhaler and the rescue inhaler would need to remain on the medication	D 378		

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D 378	Continued From page 119 cart for the MAs to administer to the resident. Interview with the Health and Wellness Director (HWD) on 05/20/24 at 6:38pm revealed: -A resident could self-administer medications if there was a physician's order for the resident to self-administer medication and she has completed a Self-Administer medications Assessment on the resident. -Resident #3 did not have an order to self-administer any medications. -There was not a physician order for Resident #3 to self-administer any medications. -There should not have been inhalers in Resident #3's room for her to self-administer because there was not a physician order, or a self-administer medications assessment completed by the facility. Attempted telephone interview with Resident #3's primary care physician (PCP) on 05/17/24 at 9:03am was unsuccessful.	D 378		
D 382	10A NCAC 13F .1006 (f) Medication Storage 10A NCAC 13F .1006 Medication Storage (f) Medications requiring refrigeration shall be stored at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C). This Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure medications requiring refrigeration were stored at 36 degrees Fahrenheit (F) to 46 degrees F.	D 382		

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D 382	Continued From page 120 The findings are: Review of the facility's medication storage policy dated October 2018 revealed: -Medications and treatments should be stored in an organized manner under proper conditions of sanitation, temperature, moisture, and light in accordance with the manufacturer's instructions. -Medications requiring refrigeration should be stored in a refrigerator located in the drug room at the nurse's station or other secure location. -Associates should check the temperature of the refrigerator daily to verify the optimum temperature, and record in the medication refrigerator log. -If the temperature is 2 degrees greater or less than the optimum range, notify the Administrator or the Health and Wellness Director (HWD) and document action taken. Observation of the facility's medication storage room on 05/15/24 from 7:20am to 7:26am revealed: -The door to the medication storage room was opened and the medication storage room was visible from the hallway. -There was a placard on the door with "Please Keep Door Closed." -There was a placard on the wall to the right of the medication storage room with "Medication Room." -There was a small refrigerator on the left side of the medication storage room. -The refrigerator was not locked and there was a padlock on the top of the refrigerator. Observation of the unlocked refrigerator on 05/15/24 at 7:27am revealed: -There were four unopened boxes of Latanoprost	D 382		

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D 382	Continued From page 121 Solution 0.005% eye drops (Latanoprost is used to treat glaucoma) in the refrigerator. -There was one box of Formoterol Fumarate Inhalation Solution 20mcg/2 mL vials that contained 15 individually wrapped vials (Formoterol Fumarate Inhalation Solution is used to treat wheezing, shortness of breath, and chest tightness caused by chronic obstructive pulmonary disease) in the refrigerator. -There were two unopened blue plastic bags that each contained one prescription bottle labeled with Aplisol Injectable 5TU/0.1mL in a 5 mL multiple dose vial (Aplisol is a solution used to test for tuberculosis) in the refrigerator. Observation of the unsecured refrigerator in the medication storage room on 05/15/24 from 7:28am to 7:41am revealed: -There was an industrial rectangular thermometer in the second section of the side of the refrigerator with a temperature of 76 degrees F. -There was a round thermometer with an adhesive back stuck to the left side of the refrigerator in between the first and second shelf of the refrigerator with a temperature of 74 degrees F. -There was a temperature dial under the first shelf of the refrigerator to the right that was set on four. -The temperature dial under the first shelf of the refrigerator to the right showed the refrigerator could be set up to five. Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/17/24 at 4:27pm revealed: -Medications that pharmacy has noted on a prescription label with refrigerate should be refrigerated. -Latanoprost eye drops per the manufacturer's	D 382		

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D 382	Continued From page 122 storage directions should be stored between 36 degrees F to 46 degrees F. -Once Latanoprost eye drops have been opened, it could be stored at 77 degrees F or lower. -Formoterol Fumarate Inhalation Solution 20mcg/2 mL vials should be stored between 36 degrees F to 46 degrees F. -Aplisol Injectable 5TU/0.1mL in a 5 mL multiple dose vials should be stored at 36 degrees F to 46 degrees F. -Latanoprost, Formoterol Fumarate, and Aplisol could lose their effectiveness if not stored at the manufacturer's storage directions. Review of the facility's medication room refrigerator temperature log for April 2024 revealed: -There was an entry on 04/24/24 at 12:15am that the refrigerator temperature was 30 degrees F. -There was an entry of not applicable (N/A) in the action taken column. -There was an entry on 04/27/24 at 2:40am that the refrigerator temperature was 34 degrees F. Review of the facility's medication room refrigerator temperature log for May 2024 revealed: -There was an entry on 05/01/24 at 12:00am that the refrigerator temperature was 34 degrees F. -There was an entry of N/A in the action taken column. -There was an entry on 05/03/24 at 12:15am that the refrigerator temperature was 35 degrees F. -There was an entry of N/A in the action taken column. -There was an entry on 05/15/24 at 12:07am that the refrigerator temperature was 78 degrees F. -There was an entry that the refrigerator was unplugged in the action taken column.	D 382		

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D 382	Continued From page 123 Review of the facility's medication room refrigerator temperature log revealed: -There were directions to check the temperature of the refrigerator daily. -Staff should record the temperature on the refrigerator temperature log one time a day. -The normal temperature range should be between 35 degrees Fahrenheit (F) to 46 degrees F. -If the temperature was 2 degrees below 35 degrees F to 46 degrees F or 2 degrees above 35 degrees F or 46 degrees F notify the Administrator or the Health and Wellness Director (HWD) and document the action taken. -There was a place for staff to document the month and year at the top of the form. -There were five columns on the medication room refrigerator temperature log for staff to complete including the date, time, temperature, staff signature, and action taken. Interview with the Resident Care Coordinator (RCC) on 05/15/24 at 7:52am revealed: -She was not aware that the refrigerator in the medication room was not working. -A personal care aide (PCA) on 3rd shift was responsible for checking the refrigerator temperature and logging it in the refrigerator temperature logbook. -Medications in the refrigerator should be refrigerated because of the directions on the pharmacy packing to refrigerate the medications. Interview with the Administrator on 05/20/24 at 7:05pm revealed: -Staff should have contacted the HWD or him on 05/15/24 when the refrigerator temperature was 78 degrees F, so accommodation could have been made to ensure medications that required refrigeration could be stored correctly.	D 382		

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D 382	Continued From page 124 -He expected staff to ensure that the refrigerator for medication storage was working correctly.	D 382			