STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(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) COMPLETION DATE
E 000	Initial Comments An unannounced refortification survey was conducted on 07/08/2019 through 07/11/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID TGFH11.	E 000		
F 000	INITIAL COMMENTS There were no deficiencies cited as result of the Recertification survey and complaint investigation. 5 of the 5 complaint allegations were unsubstantiated. Event ID# TGFH11.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:	F 576		7/12/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/02/2019

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F 576	Continued From page 1 (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to deliver mail to residents on Saturdays. The findings included: A Resident Council Meeting was conducted with 9 residents on 7/11/19 at 10:00am. During the Resident Council Meeting it was revealed mail was not delivered on Saturdays. The Activity coordinator who was present during the resident council meeting indicated she did not work on Saturdays and was not present to deliver residents mail. On 7/11/2019 at 10:36 am, an interview with the Administrator revealed that the Activity Director did not work on weekends and stated there was not a current plan in place to deliver Saturday mail to the residents. She further indicated that the facility should provide Saturday main delivery.	F 576	"On 07/11/2019, Administrator appointed one facility employee to pick up mail on Saturdays and deliver it to residents. "On 07/11/2019, Administrator created a sign off sheet for appointed employee to utilize to verify mail is picked up on Saturday and delivered to the residents. "On 07/11/2019, Administrator educated appointed facility employee on facility expectation of mail delivery to residents to include picking up the mail on Saturdays, delivering it to the residents, completing the sign off sheet and submitting it to Administrator. "For continued monitoring, the Administrator will review the sign off sheet weekly to ensure mail is picked up on Saturdays and delivered to the residents. Audit is to continue weekly times 4 weeks	

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F 576	Continued From page 2	F 576	and monthly thereafter. "Results of mail delivery audit will be presented at next scheduled Quality Assurance Committee meeting for review and again the following Quality Assurance Committee meeting with determination at that time for continued need for monitoring.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		8/12/19

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F 656	Continued From page 3 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow care plan interventions for 1 of 1 resident (Resident #51). The findings included: Resident #51 was admitted to the facility on 06/30/2018 with diagnoses that included Dependence on Renal Dialysis. Review of the Annual Minimum Data Set (MDS) Assessment dated 06/19/2019 revealed Resident #51 with moderately impaired cognition and received dialysis. The Care Plan of Resident#51 dated 06/28/2019 revealed interventions that included communication with Dialysis Treatment Center as indicated for adjustments in resident's care with notification of physician and monitor labs and report to doctor as needed.	F 656	For resident #51: "On 06/03/2019, Jones County Dialysis Center was notified by nurse of positive occult results for resident #51. "On 06/03/2019, Jones County Dialysis Center notified facility of scheduled appointment for resident #51 with Dr. Patricia Lewis at CCHC Southern Gastroenterology Associates. "On 06/25/2019, after speaking with resident #51 responsible party, it was determined that resident was to have colonoscopy and scheduled it for next available appointment on 12/30/2019 with request to visit sooner at office with any increasing complaints. For resident #51 and all other residents: "On 07/11/2019, Administrator initiated an	

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F 656	Continued From page 4 Review of Resident #51 dialysis center Physician order dated 05/27/19 indicated to perform occult stool for a low hemoglobin result of 7.6. A facility physician order dated 5/27/19 revealed that Resident #51 would have occult stools x3. Review of (Activities of Daily Living) ADL Flow Record under bowel function revealed Resident #51 did not have bowel movement on 05/28/19, and 05/29/19 but had bowel movements night shift of 05/27/19, night shift and day shift of 05/31/19 but no occult stool test was done. The Medication Administration Record (MAR) for May 2019 revealed no documentation that Resident #51 had an occult stool test done from 5/27/19 through 5/31/19. Interview with the DON on 07/11/19 at 03:18PM revealed the facility should follow the physician orders to obtain labs. She further stated the physician ordered occult stool test should have been collected upon Resident #51 first stool. According to Resident #51 bowel record (ADL Flow sheet) the occult stool test should have begun on the date of the residents next stool. The responsible nurse should have contacted the dialysis center to notify them the residents occult stools was not completed as ordered. Care plans should be followed as written.	F 656	in-service for all facility licensed nursing staff to be conducted by Staff Development Coordinator/Designee on facility care plan policy focusing on communication with Dialysis Treatment Center as indicated for adjustments in resident□s care with notification of physician and monitor labs and report to doctor as needed. Any facility licensed staff not in-serviced on 07/11/2019 will be prior to next scheduled shift. "On 07/11/2019, Administrator initiated a chart audit for all dialysis residents to be conducted by MDS Coordinator/Designee of the last three months to ensure any adjustments in resident□s care is communicated to the dialysis center physician in a timely manner to include monitoring labs and reporting to doctor as needed. Any adjustments in resident care found not to be communicated with Dialysis Center will be immediately. Audit is to be complete on 07/12/2019. "For continued monitoring, Administrator initiated random chart audit of 25% in-house dialysis residents to ensure any adjustments in resident□s care is communicated to the Dialysis Center physician in a timely manner to include monitoring labs and reporting to doctor as needed. Audit to continue weekly times 4 weeks to total 100% and monthly thereafter. "All newly employed licensed nursing staff will be educated on the facility care plan policy focusing on communication with	

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F 656	Continued From page 5	F 656	Dialysis Treatment Center as indicated for adjustments in resident□s care with notification of physician and monitor labs and report to doctor as needed. "Results of audit will be presented at next scheduled Quality Assurance Committee meeting for review and again the following Quality Assurance Committee meeting with determination at that time for continued need for monitoring.	
F 924 SS=D	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain 8 of 26 hand rails on hall 100. The findings included: Interview with the Maintenance Director on 7/8/19 at 1:29pm revealed he was notified of items in the facility that needed repair verbally staff and residents. He further indicated that he had a white board that staff and residents could also utilized to communicate maintenance concerns. Observation of hall 100 on 7/10/19 at 2:00pm reveled 8 handrails were loose to touch and not secure to the wall. Interview and observation with the Maintenance Director on 7/11/19 at 8:33am revealed the handrails were loose and were going to be	F 924	"On 07/11/2019, Maintenance Director firmly secured the 8 handrails that were loose to touch. "On 07/12/2019, Administrator in-serviced Maintenance Director on importance of firmly secured handrails on each side of the corridors. "On 07/12/2019, Administrator initiated an audit to be conducted by Maintenance Director/Designee on ensuring all facility handrails were firmly secured on each side of the corridors. Any handrails identified to be loose are to be immediately secured. Audit to be complete on 07/15/2019. "For continued monitoring, random selection of 25% of facility handrails are to	8/15/19

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F 924	Continued From page 6 replaced. He further indicated that although the handrails were loosed they could still hold his weight and were not going to come from the wall. Interview and observation with the Administrator on 7/11/19 at 10:00am revealed the facility was implementing new handrails. She further indicated the hand rails were to be maintained until the new handrails were put into place.	F 924	be checked to ensure they are firmly secured on each side of the corridors. Audit to continue weekly times 4 weeks to total 100% and monthly thereafter. "Results of audit will be presented at next scheduled Quality Assurance Committee meeting for review and again the following Quality Assurance Committee meeting with determination at that time for continued need for monitoring.	