STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKRIDGE RETIREMENT COMMUNITY	1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106

(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 recertification survey was conducted on 8/2/21/ to 8/5/21. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID# ILEY11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/2/21-8/5/21. Event ID# ILEY11 4 of the 4 complaint allegations were unsubstantiated.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications that were left at bedside for 1 of 5 residents reviewed for unnecessary medications (Resident #24). The findings included: Resident #24 was admitted to the facility on 2/24/18 with a diagnosis of osteoarthritis. An annual Minimum Data Set assessment dated 7/28/21 revealed Resident #24 was cognitively intact. On 8/2/21 at 2:51 PM, a bottle of roll-on	F 554	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 554 Resident Rights /Self-Administer Medications Immediately, the charge nurse removed	8/20/21

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

Electronically Signed | 08/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKRIDGE RETIREMENT COMMUNITY	1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106

(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
F 554	Continued From page 1 aspercreme with lidocaine was observed on the bedside table. During an interview with Resident #24 on 8/2/21 at 2:51 PM, she stated she used the roll-on aspercreme for her back and sometimes her knees. On 8/2/21 at 4:13 PM, Nurse #1 was interviewed. She stated Resident #24 had an order for a Lidoderm patch but not for the roll-on aspercreme. Nurse #1 added she did not know if the medication should be left on the bedside table and that Resident #24 ' s family member may have brought the medication in. A comprehensive medical record review conducted on 8/2/21 did not include an order an assessment to self-administer medications was completed on Resident #24. On 8/5/21 at 11:00 AM, the Administrator was interviewed. She stated she was not aware Resident #24 had medications at the bedside but thought her family member may have brought them in.	F 554	the medication at resident bedside. Administrator found medication at bedside were provided by the resident□s family. Assistant Director of Nursing reminded family to provide medications to the nurse. The medications were removed and resident was assessed for self-administration of medication by Assistant Director of Nursing and Nursing Supervisor. All residents have the potential to be affected by family leaving medication at bedside. 100% audit of certified rooms was completed by Assistant Director of nursing, Nursing Supervisor and MDS Nurse with no further observations of medications at bedside. This audit was completed 8/9/2021. Education was completed with staff by Assistant Director of nursing to confirm that if medications are found at resident bedside, they should be removed immediately and nursing supervisor should be notified. The nurse should then complete an assessment for self-administration of medications. Education completed 8/20/2021. Three times a week for 5 weeks, the DON or designee will round on all certified beds to ensure medications are not being left at bedside. If a medication is found, the DON or designee will ensure appropriate steps have been taken to ensure the Resident Right to self-administer medications are upheld. The audits will be reviewed by the facility QAPI Committee to determine if further auditing is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKRIDGE RETIREMENT COMMUNITY	1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106

(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
F 554	Continued From page 2	F 554	Responsible Role: DON Date of Compliance: 8/20/2021	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of transfer status, medications and active diagnosis for 1 of 5 residents reviewed for unnecessary medications (Resident #27) and discharge location for 1 of 3 closed records reviewed (Resident #33). The findings included: 1. Resident #27 was admitted to the facility on 1/11/21 with diagnoses of schizophrenia, dementia, and insomnia. A physician's progress note dated 6/8/21 by the physician revealed Resident #27 had a history of schizoaffective disorder. A quarterly Minimum Data Set (MDS) assessment dated 7/20/21 revealed Resident #27 had severely impaired cognition. For transfer assistance, the MDS was coded as totally dependent with assistance of 1 person. Schizophrenia was not added to Resident #27's active diagnosis on the MDS. The MDS revealed Resident #27 received 7 days of a hypnotic during the assessments look back period.	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 641 Accuracy of Assessments Immediately, the MDS corrections were submitted by the MDS Nurse and Assistant Director of Nursing to ensure the resident assessment accurately reflected the resident needs. Completed 8/5/2021. All residents have the potential to be affected by inaccurate coding. A review of MDS data assessments from the last 30 days was completed by the MDS Nurse to ensure assessments were accurate. The assessments were corrected if the need was observed. Completed 8/18/2021. Education was completed with MDS by	8/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKRIDGE RETIREMENT COMMUNITY	1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106

(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
F 641	Continued From page 3 Physician orders for July 2021 revealed an order for Melatonin 3 milligrams at bedtime and an order for Zyprexa 15 milligrams at bedtime for schizophrenia. A review of the July 2021 Medication Administration Record (MAR) revealed Resident #27 received Melatonin 3 milligrams at bedtime 7 out of 7 days of the look back period and Zyprexa 15 milligrams at bedtime for 7 out of 7 days of the look back period. A nurse's note dated 7/19/21 at 9:10 AM revealed Resident #27 was non-ambulatory and required 2 person assist via a mechanical lift for transfers. A nurse's note dated 7/29/21 at 2:26 AM revealed Resident #27 required 2-person assistance for transfers. An interview was conducted with NA #1 on 8/3/21 at 11:30 AM. She stated Resident #27 used a mechanical lift and 2- person assistance for transfers. On 8/5/21 at 10:30 AM, the MDS nurse was interviewed. She stated she was new to her role and received a lot of training. She added one of the things she learned was about medications and she had a list that indicated melatonin was to be coded as a hypnotic on the MDS. She further stated schizophrenia should have been added as a diagnosis and the transfer status on the MDS should have been coded as 4/3, for 2-person assistance. 2. Resident #33 was admitted to the facility on 6/15/21 from the hospital.	F 641	the Administrator to ensure the importance of accurate assessments was expressed. MDS Nurse acknowledges that she understands she must accurately code for the facility to be in compliance with CMS. The facility administrator spoke with the Medical Director ensuring physician notes were an accurate reflection of the resident. Education completed 8/20/2021. Three times a week for 5 weeks, the DON or RN designee will perform a second check on submitted MDS assessments to ensure assessments are accurate. The audits will be reviewed by the facility QAPI Committee to determine if further auditing is necessary. Responsible Role: DON Date of Compliance: 8/20/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKRIDGE RETIREMENT COMMUNITY	1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106

(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
F 641	Continued From page 4 A discharge Minimum Data Set (MDS) assessment dated 7/18/21 revealed Resident #33 was discharged to the hospital. A nurse's note dated 7/18/21 at 2:24 PM revealed Resident #33 was transferred back to his independent living apartment. On 8/3/21 at 3:05 PM, the Admissions Director was interviewed. She stated Resident #33 was admitted following a procedure on 6/15/21 and went back to his living apartment on 7/18/21. On 8/5/21 at 10:30 AM, the MDS nurse was interviewed. She stated Resident #33 was discharged back to independent living and the MDS was coded incorrectly.	F 641		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		8/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKRIDGE RETIREMENT COMMUNITY	1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106

(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
F 842	Continued From page 5 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKRIDGE RETIREMENT COMMUNITY	1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106

(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
F 842	Continued From page 6 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and nurse practitioner interview, the facility failed to maintain an accurate medical record regarding code status for 1 of 13 residents reviewed for advanced directives (Resident #20). The findings included: Resident #20 was admitted to the facility on 3/18/21 with diagnoses of fracture of upper end right humorous and chronic obstructive pulmonary disease. A physician's order dated 3/18/21 read "DNR" (do not resuscitate). The electronic health record included a portable DNR dated 3/18/21. A progress note dated 3/22/21 by the Nurse Practitioner #1 read, "visit for evaluation of new patient. Code status: full code. Discussed with patient 3/22/21 and she wants all measures of resuscitation." A progress note dated 6/8/21 by Nurse Practitioner #2 read, "seen for emergency room visit. Active advanced directive MOST (medical orders for scope of treatment) form updated on	F 842	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F842 Resident Records- Identifiable Information Immediately, Resident #20 code status was confirmed by the Administrator and Assistant Director of Nursing with the resident and provider, as well as the survey team prior to exit. Completed 8/5/2021. All residents have the potential to be affected by inaccurate code status. Assistant Director of Nursing and MDS Nurse reviewed all code status preferences with each resident. Completed 8/18/2021. Education was completed by the Administrator with admissions staff, MDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKRIDGE RETIREMENT COMMUNITY	1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106

(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
F 842	Continued From page 7 5/27/21. Patient is a DNR with limited interventions." A progress note dated 6/21/21 by Nurse Practitioner #1 read, "Code status: full code. Discussed with patient 3/22/21 and she wants all measures of resuscitation." A progress note dated 7/14/21 by Nurse Practitioner #1 read, "Code status: full code. Discussed with patient 3/22/21 and she wants all measures of resuscitation." An interview was conducted on 8/4/21 at 3:09 PM with Nurse Practitioner #1. She stated Resident #20 went out to the hospital and she had not updated her note.	F 842	Staff, and nursing staff to ensure that annual code status audits are completed, code status is reviewed at each quarterly assessment, and code status is reviewed at resident care plans. The care plan tool was updated by the Administrator to reflect need to cover Code Status. Education completed 8/20/2021. Once a week for 5 weeks, the DON or designee will audit 5 residents to ensure care plans, physician notes, and new admissions to match the code status in the system accurately. The audits will be reviewed by the facility QAPI Committee to determine if further auditing is necessary. Responsible Role: DON Date of Compliance: 8/20/2021	