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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 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on May 31, 2017 and June 1, 2017.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the implementation of a Primary Care Provider (PCP) order for supplemental oxygen as evidenced by a failure to prompt 1 of 2 sampled residents (#1) with a diagnosis of Dementia who had been hospitalized on 5/24/17 for breathlessness on exertion, to wear oxygen when ambulatory, assure that an adequate supply of portable oxygen was available and report any non-usage of supplemental oxygen as ordered was reported to the PCP. The findings are: Review of Resident #1's current FL-2 dated 1/10/17 revealed diagnoses included Peripheral Vascular Disease, Vascular Dementia,	D 276		

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D 276	Continued From page 1 Hypertension, Major Depressive Disorder, Left Foot Wound and Left Toe Amputation. Review of a "Physician's Orders" sheet for Resident #1 dated 4/28/17 revealed there was an order for oxygen (O2) at 2 liters (L) via nasal cannula (NC) to maintain oxygen saturation (O2 sat) greater than 90% signed by the Primary Care Provider (PCP). Interview with the facility RN on 5/31/17 at 5:55pm revealed: -The facility did not check or monitor oxygen saturation levels. -She would have to contact the PCP and get clarification on that order. Review of a cardiologist visit note for Resident #1 dated 4/27/17 revealed: -Resident #1 had been newly diagnosed with Diastolic Heart Failure and Pulmonary Hypertension following progressive difficulty breathing on exertion for two months. -Her PCP had recently ordered oxygen because she had de-saturated to 83% with activity. Interview with Resident #1 on 5/31/17 at 11:42am revealed: -She used her oxygen while she was in her room because the small tanks were empty. -She knew the tanks were empty because the plastic ring was no longer on the tanks. -She thought the tanks may have been empty for three days. -She "probably did" tell staff she needed new tanks. -She did not know how to get refilled oxygen tanks. -She used to carry a tank with her in case she needed it, but there were no oxygen tanks to use	D 276		

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if she needed to leave the room.
-She had shortness of breath if she walked too fast.
-She had missed one doctor's appointment the "other day" because she went to the hospital for "shortness of breath" and "tightness" in her chest.
-The hospital said it was not her heart.
-She had an appointment coming up with the doctor, but she did not know when.

Observations on 5/31/17 from 11:42am until 12:25pm revealed:
-There was an oxygen in use sign on the door of room #F8.
-Inside room #F8, there was a large oxygen tank inside a stand behind Resident #1's chair.
-There were seven small tanks inside a rack next to the resident's bed.
-Resident #1 was sitting in her chair with the television on wearing a nasal cannula connected to an oxygen concentrator set at two liters per minute.
-At 11:58am, another resident came to "help" Resident #1 to the dining room for lunch.
-Resident #1 walked slowly down the L shaped hallway with her Rollator from her room to the dining room with increased effort to breathe beginning at the bend in the hallway which was approximately 25 feet from her room.
-She stopped for a minute to catch her breath and had difficulty talking and walking.
-There was no portable oxygen tank on her person or in the compartments on the Rollator.
-She arrived at the F hall dining room and seated herself in a chair at the first table to the left.
-The other resident stayed with Resident #1 the entire way from room #F8 to the F Hall dining room and assisted the resident with "parking" her Rollator in the dining room.
-There was no staff present until after her arrival

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in the dining room.
-Staff served beverages, the lunch meal and desserts from 12:07pm until 12:25pm.
-Resident #1 ate lunch and was not wearing oxygen.
-She did not have signs of difficulty breathing while she was eating lunch.

Telephone interview with the facility Registered Nurse (RN) on 5/31/17 at 12:07pm revealed:
-Resident #1 had orders for 2L O2 continuous while ambulating.
-Staff ordered new oxygen tanks when the resident was low, and the medical equipment company would bring new tanks to the facility.

Interview with the facility RN on 5/31/17 at 12:12pm revealed:
-Staff had found a small portable tank inside Resident #1's room on the floor between a chair and a table.
-She instructed staff to place the tank inside the storage compartment of Resident #1's Rollator.
-The small portable tank was resident #1's last tank, all the other tanks in the residents room were empty.

Observations on 5/31/17 from 12:25pm until 12:42pm revealed:
-At 12:26pm the small oxygen tank was inside a shoulder bag which was inside the storage compartment in the seat of the Rollator with the NC folded in the front basket on the Rollator.
-At 12:39pm Resident #1 left the dining room alone walking slowly with her Rollator and not wearing her oxygen.
-She stopped at the F Hall common area to rest, with increased effort to breath.
-There was no staff in the hallway and no staff came to monitor her oxygen use or prompt her to

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D 276	Continued From page 4 wear the oxygen. Interview with a Personal Care Aide (PCA) on 5/31/17 at 12:10pm revealed: -She was responsible for assisting residents with activities of daily living. -She knew Resident #1 and knew she was supposed to have oxygen. -The Medication Aides (MAs) were responsible for making sure residents had portable oxygen tanks to use while walking in the hall. -She knew the resident had oxygen in her room. Interview with a MA on 5/31/17 at 12:48pm revealed: -Resident #1 was supposed to have continuous oxygen when she was walking. -The MAs were responsible for making sure the resident had oxygen and was using it every shift. -The PCAs were responsible for helping the residents with what they needed to get to the dining room. -The facility RN had called for oxygen refills on 5/31/17. -She did not know they were empty. -Resident #1 was forgetful sometimes. Interview with the facility RN on 5/31/17 at 12:50pm revealed: -There was 1000 PSI (pounds per square inch) out of 3000 PSI, remaining in the tank that was placed inside the storage compartment of Resident #1's Rollator. -She had called the medical equipment supply company for new oxygen tanks on 5/31/17. -The MAs were responsible for monitoring residents' oxygen use and supply. -The PCAs should know about residents' needs related to supplemental oxygen as well. -Resident #1 was forgetful at times.	D 276		

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D 276	Continued From page 5 Interview with Resident #1 on 5/31/17 at 12:42pm revealed: -She was sitting in the common area to catch her breath. -The oxygen tank she had with her was empty. -She had been out of the small oxygen tanks for a couple days, "maybe more." -"I did not tell anyone. It's my fault not theirs. I just take my time." Interview with the PCA on 5/31/17 at 12:46pm revealed: -She had checked the O2 tank before she placed it on Resident #1's Rollator and it was full. -Resident #1 did not get "escort services" to and from the dining room, so the PCAs did not bring her to and from the dining room. -PCAs knew what to do for each resident from a book kept downstairs in the staff break room at the facility. -The book had a list of what type of assistance residents needed for the day. Review of Licensed Health Professional Support (LHPS) evaluation for Resident #1 dated 4/2/17 revealed: -Oxygen administration and monitoring was documented as a task and there was an "X" mark next to yes for staff competency validated. -The assessment narrative note documented: "Recent order for O2 2L via NC continuous and resident refuses to use O2 outside of her room. MD and POA (Power of Attorney) aware." -Recommendations were documented to continue to monitor oxygen use and SOB (shortness of breath) and notify MD/RN of significant changes. -The evaluation was signed by the facility RN.	D 276		

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Attempted interview with Resident #1's Power of Attorney (POA) on 6/1/17 at 10:52am was unsuccessful.

Observation on 5/31/17 at 4:58pm revealed Resident #1 was sitting in the F Hall dining room for the dinner meal and was not wearing oxygen.

Observation on 6/1/17 at 8:20am revealed Resident #1 was sitting in the F Hall dining room for the breakfast meal and was not wearing oxygen.

Interview with Resident #1 on 6/1/17 at 8:54am revealed:
-She was "winded."
-"I get short of breath when I walk down that long hallway."
-She always wore her oxygen when she was in her room, did not like to wear it while she was eating and knew she should wear it when she was walking to and from the dining room.
-Her breathing "always comes back" when she "sits for a while."
-New oxygen tanks had not been delivered yet.

Observation on 6/1/17 at 8:54am revealed the small portable oxygen tank remained inside the storage compartment of Resident #1's Rollator.

Telephone interview with the medical equipment supplier Receptionist on 6/1/17 at 8:59am revealed:
-The company began supplying supplemental oxygen for Resident #1 on 5/1/17.
-Since 5/1/17 the only request the company had received for refills was on 5/31/17.
-New oxygen tanks were delivered on request.
-How long a supply would last would vary from person to person depending on their usage.

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D 276	Continued From page 7 Review of a "Fax Transmittal Sheet" for Resident #1 dated 5/3/17 revealed: -The sheet was addressed to Resident #1's PCP documenting the resident "used oxygen continuously while she was in her apartment and was refusing to use it when out of [her] apartment." -There was documentation, "SOB (shortness of breath) with ambulation continues. We will continue to monitor and inform you of any changes." -The document was signed by the facility RN. Review of a "Physician's Order" form for Resident #1 dated 5/4/17 revealed there was an order for "O2 on ambulation/exertion only to maintain (O2) saturation greater than 90%,"signed by the PCP. Review of an untitled document from the "Care Plan" Book revealed: -There was documentation at the beginning of document addressed to staff that the writer would be "out until Tuesday next week. Here's some stuff for you all to know." -Next to Resident #1's name, there was documentation she was sent to the emergency room on Wednesday afternoon ..."she needed new oxygen tanks (small ones), [name of MA] may have already ordered from [name of company]. Someone please ensure that was done." -There was no date or signature on the document. Interview with the named MA on the untitled document on 6/1/17 at 5:18pm revealed: -She placed an order for the oxygen on the day Resident #1 was sent to the hospital (5/24/17). -She called [name of medical supply company]	D 276		

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and left a message on their afterhours message line.
-She was not working on 5/25/17 so she did not know what happened after that.
-The medical supply company usually delivered the next day.
-She reported making the refill request to oncoming (3rd) shift MA during report.
-The oncoming shift MA would have been responsible for any follow up.

Review of a hospital discharge summary for Resident #1 dated 5/25/17 revealed:
-The resident was admitted to the hospital on 5/24/17 with a diagnosis of Breathlessness on Exertion and was discharged on 5/25/17.
-Under the "Medication List" section, there was documentation under a subtitle of "Miscellaneous Medical Supply" the resident's O2 level (oxygen saturation) was 94%, then after 30 feet of walking dropped to 86% on room air. [Resident] was placed on 2L O2, (O2) saturation came up to 91% and remained after walking 8 feet.

Review of the hospital history and physical for Resident #1 dated 5/25/17 revealed:
-Resident #1 presented to the hospital with chest pain, difficulty breathing for one week and a three pound weight gain for a possible component of fluid overload.
-The resident reported having increased difficulty breathing with ambulation and increased lower extremity swelling.

Review of "Resident Log" for Resident #1 revealed:
-On 5/3/17 at 10:00am the facility RN documented the resident refused to wear oxygen outside her apartment, PCP notified by fax, the POA was notified and the resident would be

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monitored for SOB with ambulation and any changes would be reported to the PCP.
-On 5/4/17 for 11:00pm-7:00am, a MA documented "Resident had no complaints regarding O2 usage. Maintained O2 usage while sleeping, however removed the cannula to get dressed for the day. [MA] reminded resident to reapply once she was done. Resident Complied."
-On 5/4/17 at 2:30pm, a MA documented the resident had been wearing O2.
-On 5/6/17 at 10:30am, the facility RN documented the resident had been wearing O2.
-On 5/24/17 at 4:00pm, a MA documented the resident was sent to the emergency room for complaints of chest pain and being hot and sweaty.
-On 5/25/17 at 4:30pm, a MA documented the resident returned to the facility.
-On 5/31/17 at 12:00pm, the facility RN documented [name of company] was contacted for O2 delivery.
-On 5/31/17 at 6:30pm, the facility RN documented the resident's PCP was faxed to discontinue the O2 saturation monitoring portion of the O2 order.

Review of "Fax Transmittal Sheets" and the "Resident Log" for Resident #1 revealed:
-There were no further notifications to the PCP regarding the resident refusing to wear oxygen while ambulating after 5/3/17.
-There was no documentation of a request for oxygen refills prior to 5/31/17.

Review of a "Physician's Order" sheet for Resident #1 dated 6/1/17 revealed:
-There was an order to send [the resident] to the clinic for vital signs and an O2 saturation check with the nurse on 6/1/17 or 6/2/17.
-There was an order stating the O2 saturation did

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not need to be checked.
-There was an order to continue O2 by nasal cannula with ambulation.

Interview with a second MA on 6/1/17 at 5:34pm revealed:
-Resident #1 was supposed to wear 2L O2 via NC while she was in her room.
-The MA was responsible for checking the O2 every shift and documenting on the Medication Administration Record (MAR).
-Any staff person could check and make sure the resident was using the oxygen, but "ultimately it was the MA's responsibility."
-Resident #1 normally went to the dining room by herself because she did not have an escort.
-Resident #1 knew she was supposed to wear her O2, but "sometimes she did not want to."
-When the resident refused to wear her O2, the MA would report it to the facility RN and document it in the resident's notes.

Review of Resident #1's May 2017 electronic MARs (eMAR) revealed:
-There was an entry for oxygen at flow rate of 2L per minute per nasal cannula while ambulating and on exertion to maintain O2 saturation above 90% scheduled for day, evening and night.
-There were staff initials entered from 5/10/17 through 5/31/17 except on 5/24/17 and 5/25/17.
-There was a second entry for O2 at 2L via NC every shift for SOB scheduled for day, evening and night.
-There were staff initials entered from 5/1/17 through 5/31/17.

Interview with the facility RN on 6/1/17 at 11:15am and 12:50pm revealed:
-The facility had borrowed another tank for Resident #1 for 6/1/17.

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D 276	Continued From page 11 -The new oxygen tanks were expected to be delivered on 6/1/17. Telephone interview with Resident #1's Primary Care Provider (PCP) on 6/1/17 at 12:18pm revealed: -She had spoken with facility staff regarding the oxygen saturation level monitoring on 6/1/17 which was discontinued because it was more for home health monitoring. -She requested Resident #1 be brought to the clinic for a nurse visit on 6/1/17 to check her oxygen saturation level. -Resident #1 did not need the oxygen when she was in her room, she needed the oxygen when she was up and walking around. -Resident #1 had worsening heart failure and the plan was for supplemental oxygen, to diures her and monitor her weight and lab values. -When the resident gains weight it was an indication of increased fluid and would contribute to her difficulty breathing. -Resident #1's POA requested the daily weights be discontinued and called about her oxygen as well. -Resident #1's dementia was "too advanced" for her to weigh herself, write it down and remember to put oxygen on before leaving her room. -She expected staff to provide prompts and reminders to Resident #1 to wear her oxygen and weigh herself. -If the resident refused or her condition worsened, the PCP expected staff to notify her. -She had not been notified the resident had refused to wear her oxygen while ambulating since 5/3/17. Interview with the Administrator on 6/1/17 at 11:15am and 2:55pm revealed: -The were additional service fees for medication	D 276		

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administration, assistance to the dining room (escort), weights, oxygen monitoring, feeding assistance; "all of that."
-Fees were based on the residents service plan which was approved by the resident and/or POA.
-She was not aware supplemental oxygen was not on Resident #1's service plan (care plan) and that staff were not aware to check on resident prior to ambulation because it was not part of her service plan.
-There appeared to be a gap in the system for monitoring oxygen use.
-Resident #1's service plan would be updated and staff would be trained on monitoring oxygen use.

The facility failed to assure the implementation of a Primary Care Provider (PCP) order for supplemental oxygen as evidenced by a failure to prompt 1 of 2 sampled residents (#1) with a diagnosis of Dementia who had been hospitalized on 5/24/17 for breathlessness on exertion, to wear oxygen when ambulatory, assure that an adequate supply of portable oxygen was available and report any non-usage of supplemental oxygen as ordered was reported to the PCP. The facility's failure to provide and monitor supplemental oxygen for Resident #1 was detrimental to the safety and wellbeing of residents, which constitutes a Type B Violation.

Review of the Plan of Protection submitted by the facility on 6/1/17 revealed:
-The order for oxygen saturation monitoring for Resident #1 was discontinued by the PCP at 1pm on 6/1/17.
-The PCP clarified the supplemental oxygen order for Resident #1 for use with ambulation.
-Resident #1's care plan was updated and sent to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032016	A. BUILDING: _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHAPEL HILL AL (NC)	2220 FARMINGTON DRIVE CHAPEL HILL, NC 27514

(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 276	Continued From page 13 the PCP for signing. -There will be an immediate in-service with all associates regarding oxygen use, monitoring and supply ordering. -A note will be added to the Personal Service Plan on how to monitor the usage of oxygen and reporting for 30 days. -Associates will be expected to initial assignment sheet each shift for all residents for 30 days and the facility RN will monitor this process. -MAs will be expected to document on each shift log any oxygen usage. -If a resident does not use oxygen, the MA will document in the resident's record and notify the PCP. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 7/16/17.	D 276		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care.	D912		

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D912	Continued From page 14 The findings are: Based on observations, interviews and record reviews, the facility failed to assure the implementation of a Primary Care Provider (PCP) order for supplemental oxygen as evidenced by a failure to prompt 1 of 2 sampled residents (#1) with a diagnosis of Dementia who had been hospitalized on 5/24/17 for breathlessness on exertion, to wear oxygen when ambulatory, assure that an adequate supply of portable oxygen was available and report any non-usage of supplemental oxygen as ordered was reported to the PCP. [Refer to Tag 276 10A NCAC 13F .0902(c)(4) Health Care (Type B Violation)]	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which	D935		

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D935	Continued From page 15 bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 2 sampled medication aides had completed a medication skills competency prior to administering medications to residents. The findings are: Review of Staff B's employee record revealed: -Staff B was hired on 7/12/12 as a Medication Aide (MA)/Supervisor. -There was no documentation that Staff B had completed a medication skills competency evaluation prior to administering medications. Attempted interview via telephone with Staff B on	D935		

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D935	Continued From page 16 6/1/17 at 8:26pm was unsuccessful. Interview with the Business Office Manager (BOM) on 6/1/17 at 5:00pm revealed: -He reviewed employee records "all the time" to make sure documentation was complete. -Sometimes things fell through the cracks because he had a lot of trainings to coordinate. -He was responsible for making sure new employees completed required trainings and existing employees completed continuing education trainings. Interview with the Administrator on 6/1/17 at 5:00pm revealed: -She reviewed Staff B's record and thought that a second Licensed Health Professional Support (LHPS) skills check off was completed in error instead of the medication skills competency evaluation. -There would have been no need for LHPS skills evaluation on 6/22/16 when that had been done on 12/17/13. -All MAs at the facility were validated in medication skills prior to administering medications.	D935		