

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060132	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2017
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NAME OF PROVIDER OR SUPPLIER BROOKDALE COTSWOLD	STREET ADDRESS, CITY, STATE, ZIP CODE 3610 RANDOLPH ROAD CHARLOTTE, NC 28211
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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey on 11/29/17 - 12/01/17 with a telephone exit on 12/04/17.	D 000		
D 075	<p>10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(a) Adult care homes shall:</p> <p>(2) have no chronic unpleasant odors;</p> <p>This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure there were no chronic urine, feces, and body odors in 7 resident rooms (#103, #110, #203, #218, #305, #307 and #324) and in the 3rd floor hallways.</p> <p>The findings are:</p> <p>Observation on 11/29/17 during the initial tour of the facility at 9:30 am revealed:</p> <ul style="list-style-type: none"> -A strong stale, pungent urine odor was detected when exiting the elevator on the 3rd floor. -A stale urine odor was detected outside Room 305. -Upon entering Room 305, the urine odor was strong enough to make the eyes tear. <p>Observation on 11/30/17 of room #307 at 10:51 am revealed:</p> <ul style="list-style-type: none"> -There was a strong urine smell upon entering room #307. -The bathroom had fresh and dried urine on the 	D 075		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 075	<p>Continued From page 1</p> <p>floor.</p> <p>Interview on 11/30/17 with the resident of room #307 at 10:51 revealed:</p> <ul style="list-style-type: none"> -She sometimes missed the toilet when she went to the bathroom and urinated on the floor. -She tried to clean it up but was afraid that she would fall out of the wheelchair. -She called for someone to help clean it up this morning around 8 but no one came to do it. <p>Observation on 11/30/17 of room #324 at 11:45 am revealed:</p> <ul style="list-style-type: none"> -There was a strong smell of urine upon entering the room. -There were 2 plastic mattress protectors on the mattress. -The first mattress protector was covered with dried urine. -The second mattress protector, underneath the first was also covered in dried yellow urine. -The mattress also had yellow urine stains. -A strong urine odor emanated from the bed and carpet. <p>Interview on 11/30/17 with a resident in room #324 at 11:15 am revealed:</p> <ul style="list-style-type: none"> -The housekeeper cleaned her room maybe once a month. -Her carpet was cleaned about a month ago while she went to lunch. -She would like her carpets vacuumed every day because she "can't do it" herself. -She "can't get rid of the odor" (the urine smell). <p>Review of an Environmental Health Inspection for the facility dated 12/1/17 revealed:</p> <ul style="list-style-type: none"> -The facility received an overall score of 88. -There was documentation of an observation of carpet with odor in rooms 305 and 324. 	D 075		

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D 075	<p>Continued From page 2</p> <ul style="list-style-type: none"> -There was documentation of an observation of a toilet bowl in Room 110 had a strong smell. -There was documentation of an observation of a stained and/or odor from mattresses in 324, 203, and 103. <p>Observation of the facility on 12/1/17 between 8:35 AM to 11:45 am revealed:</p> <ul style="list-style-type: none"> -Room 305 continued to have a strong urine odor. -The strong urine odor in Room 305 was still present in the wheelchair and in the carpet. -There was a musty urine odor detected when the door of room 324 was open. -There was a strong smell of urine upon entering the room. -There were 2 plastic mattress protectors on the mattress. -The first mattress protector was covered with dried urine. -The second mattress protector, underneath the first was also covered in dried yellow urine. -The mattress itself had yellow urine stains. -A strong urine odor emanated from the bed and carpet. -In room 307 there was a strong urine odor detected throughout the room and in the bathroom. -In room 203 there was stained carpet with a stale musty urine odor detected. -In room 218 there was a strong stale musty urine odor detected in bedroom around the mattress. -In room 110 there was a toilet bowl that appeared to have urine and brownish fecal matter on the rim and in the bowl along with a strong odor. -In room 103 there was stained carpet with an old stale urine smell. <p>Observation on 11/29/17 at 9:30 am of room #305 revealed:</p>	D 075		

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D 075	<p>Continued From page 3</p> <ul style="list-style-type: none"> -The resident was sitting in her wheelchair. -A urinary catheter leg bag was visible at the bottom of her pants. -There was a strong odor of urine inside her room. -There was a large bedside catheter bag draped over the shower rail in her private bathroom. <p>Interview on 11/29/17 at 3:30 pm with an evening shift Medication Aide (MA) revealed:</p> <ul style="list-style-type: none"> -The resident in room #305 had an indwelling urinary catheter. -Personal Care Assistants (PCA) were responsible for emptying urine from the resident's leg catheter bag before meals and as necessary. -Staff would empty the catheter bags into a plastic garbage pail in the resident's room and would carry the garbage pail to her bathroom to empty it into the toilet. -MAs were responsible for changing the bedside catheter bag to a leg bag in the morning and then changing the leg bag back to a bedside catheter bag at night. -The catheter bags were reusable until they "leaked or urine crusted around them." -She did not have a regular schedule of changing the catheter bags because the Home Health Nurse would change them when she visited the resident. -She would hang the resident's disposable catheter bags across the shower railing in the resident's adjoining private bathroom between uses. -She did not wash or rinse out the catheter bags. <p>Telephone interview on 11/29/17 at 4:09 pm with the Home Health Nurse for the resident in room #305:</p> <ul style="list-style-type: none"> -The resident had an indwelling urinary catheter. -She was responsible for visiting the resident 	D 075		

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D 075	<p>Continued From page 4</p> <p>every two weeks to change out her catheter. -She was aware of the urine odor in room #305. -She had instructed facility staff to discard the resident's disposable leg catheter bags every 48 hours and her bedside bags one time weekly. -She had instructed facility staff to use warm, soapy water to wash out the catheter bags between uses. -Not following her instructions for care of the catheter bag could contribute to the urine odor in room #305.</p> <p>Interview on 11/30/17 at 11:03 am with a morning shift MA revealed: -The resident in room #305 had an indwelling urinary catheter. -MAs were responsible for changing her bedside catheter bag to a leg bag in the morning and then changing the leg bag back to a bedside catheter bag at night. -The catheter bags were reusable and she had never disposed of one. -She did not wash or rinse out the catheter bags.</p> <p>Telephone interview on 11/30/17 at 11:40 am with the facility's former RN revealed: -She had been employed by the facility up until August 2017. -She was responsible for training staff on urinary catheter care. -She had educated staff to dispose of leg catheter bags after each use. -Reusing the catheter bags and hanging them in the resident's bathroom could contribute to the urine odor in room #305.</p> <p>Telephone interview on 11/30/17 at 12:06 pm with the responsible party for the resident in room #305 revealed: -The resident had an indwelling urinary catheter.</p>	D 075		

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D 075	<p>Continued From page 5</p> <ul style="list-style-type: none"> -The staff were responsible for changing the bedside catheter bag to a leg bag in the morning and then changing the leg bag back to a bedside catheter bag at night. -The facility had contacted the responsible party regarding the urine odor in room #305. -She felt the odor was due to staff spilling urine onto the carpet while emptying it. -She had observed staff draining urine out of the catheter bags and hanging the used bag across the shower railing in the private bathroom of room #305. -She felt the catheter bags should be washed out to prevent the residual urine from drying in the bag. -She had discussed her concerns with the previous Executive Director (ED) and the maintenance man as well as "a new lady in the office." -She had been informed approximately 1 week ago the resident would be relocated to another room as soon as the carpet in the new room could be removed and replaced with flooring that would be more easily cleaned. <p>Interview on 11/30/17 at 4:20 pm with the Wellness Director (WD) revealed:</p> <ul style="list-style-type: none"> -The resident in room #305 had an indwelling urinary catheter. -She was aware of the urine odor in room #305. -MAs were responsible for changing the resident's bedside catheter bag to a leg bag in the morning and then changing the leg bag back to a bedside catheter bag at night. -She was unsure whether the resident in room #305 would be moved to a new room. -The resident would, at times, remove her briefs at night and her catheter would leak on her bedding. -The facility had recently replaced the mattress in 	D 075		

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D 075	Continued From page 6 room #305 to try and rid the room of urine odor. Interview on 12/01/17 at 8:45 am with the Administrator/Executive Director (ED) revealed: -He had been serving as the temporary ED of this facility for 4 days. -He was aware of the urine odor in room #305. -He was unaware of any plan to relocate the resident in room #305. -He would work with the WD on providing appropriate training to staff on the care of urinary catheters in order to help prevent future odors.	D 075		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to maintain the building, in a clean and orderly manner, free of all, hazards as related to the Speciality Care Unit (SCU) kitchenette, the 3rd floor laundry and spa and 15 residents rooms with carpet stains, food crumbs, dirty toilets, stained mattress and live roaches throughout the facility.	D 079		

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D 079	<p>Continued From page 7</p> <p>The findings are:</p> <p>Interview on 11/30/17 with a resident from room #212 at 8:30 am revealed:</p> <ul style="list-style-type: none"> -She observed "bugs" in her room and bed. -She did not know what type of bug it was. -She did not complain of bug bites. -She reported the issue with the bugs in her room and bed with the housekeeper and the maintenance man but they did not do anything about it. <p>Observation on 11/30/17 of room # 212 at 9:30 am revealed:</p> <ul style="list-style-type: none"> -There were 2 live adult roaches in the resident's personal refrigerator and 5 dead baby roaches. -There was a live roach crawling across the floor in front of the recliner where the resident was sitting. -There was a live roach crawling on the side of the resident's bed. -There was a live roach crawling on the books that were on top of the dresser in the resident's room. -There were two dead roaches on the back of the residents housecoat she was wearing. <p>Interview on 11/30/17 a second interview with the resident in room #212 at 9:30 am revealed:</p> <ul style="list-style-type: none"> -There were roaches in her room. -She asked the housekeeper to come in and vacuum many times in the past month and even asked to borrow a vacuum herself but was told no by the medication aides and no one came back to vacuum. -She has seen lots of roaches in her room and reported it to the maintenance man and the housekeeper but they had done nothing about it. -The bugs crawled on her at night and she had 	D 079		

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D 079	<p>Continued From page 8</p> <p>difficulty sleeping because of this.</p> <p>Interview with the maintenance director on 11/30/17 at 10:00 am revealed:</p> <ul style="list-style-type: none"> -They had a contracted exterminator which came out on a routine basis, once monthly. -The contracted exterminator would come and spray the problem rooms which included room 212. -He was able to call the exterminator on an "as needed basis". -They would put a "putty bait" around various parts of the building. -He had not seen any improvement with the roach population. -He did not have a full housekeeping staff until recently. -Housekeeping was responsible for cleaning the rooms according to a cleaning schedule he was able to provide. -Cleaning rooms included defrosting and cleaning refrigerators. -Room 212 should have been cleaned last Monday but was not because it was a holiday week. -They implemented a deep cleaning schedule last week. <p>Interview with a representative from the exterminator company on 11/30/17 at 11:00 am revealed:</p> <ul style="list-style-type: none"> -Their company was contracted to come out and provide extermination services monthly. -They provided extermination services on 11/20/17 as part of their monthly, routine service. -They had received a call to come and provide services on 10/02/17 as an "as needed" request. -They had not received an "as needed" call request after 10/02/17. 	D 079		

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D 079	<p>Continued From page 9</p> <p>Interview with an exterminator on 11/30/17 at 2:42 pm revealed:</p> <ul style="list-style-type: none"> -He received a call to come out to this facility at 9:30 am to check room 212 and the kitchen. -He usually sprayed based boards and set bait out and with this routine treatment the residents did not have to leave their rooms. -He observed a roach infestation in room 212 underneath the resident's chair cushion. -There were roaches of all sizes, eggs and egg carriers present in the resident's chair. -The refrigerator was also infested with roaches. -The motor of the refrigerator was a common place for roaches to nest. -Today they treated this infestation which required the resident to move out of her room at least over night because the chemicals used could be harmful to humans. -"The most important thing in treating and preventing infestations is a clean environment, sanitation". <p>Observation on 11/30/17 from 3:00 pm to 3:30 pm revealed:</p> <ul style="list-style-type: none"> -A live roach crawling on the outside of the trash can in the small serving kitchen inside the main dining room. -A live roach crawling on the floor in the hallway outside the main food preparation kitchen. -A dead roach on the floor in the main food preparation kitchen. <p>Observation on 12/01/17 entering the facility at 8:00 am revealed:</p> <ul style="list-style-type: none"> -The maintenance director was taking the recliner out of room # 212 with a hand truck with dead roaches on it. -The chair was not wrapped as to ensure any live roaches did not fall off. 	D 079		

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D 079	<p>Continued From page 10</p> <p>Observation of the facility on 12/01/17 between 8:35 AM to 11:45 am revealed:</p> <ul style="list-style-type: none"> -The carpet was stained in room 324. -The linoleum was unsecured in restroom by the shower in room 305. -There were food crumbs on the floor in room 203. -The ceiling was peeling and/or stained in 3rd floor laundry room, room 203, and in room 211's restroom. -There was a black residue on the toilet seat in room 222 and in the toilet bowl of room 110. -There were roaches in the Memory Care Unit on the short hall -There were roach droppings in the Memory Care Unit in the kitchenette on the short hall behind the cookie oven and cook book. -A documented observation of briefs and/or boxes of syringes stored on the floor in the storage room on the 3rd floor, in rooms 305 and 110A. -There were opened cereal boxes stored under the hand-sink cabinet in room 313 and briefs under the hank-sink pipe in room 307. -There were stained and/or odors from the mattresses in rooms 324, 203, and 103. -There were stained and/or torn mattress covers in rooms 324, 110A and room 117. -There was a large brown stain on the recliner seat in room 103. -There were stains and/or debris on the sheets in rooms 324 and 117. -There were stained pillows and/or pillow cases in rooms 110A -A documented observation of no thermometer in the refrigerator in rooms 332 and 226. -Room 324 had a mini refrigerator with dried brown soda in the bottom of the refrigerator and on the shelves. -Room 324 had a mattress protector covered with 	D 079		

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D 079	<p>Continued From page 11</p> <p>dried yellow urine on the mattress with a second mattress protector on top of the first one covered in dried yellow urine.</p> <ul style="list-style-type: none"> -The bed linen in room 324 had reddish-brownish color on the bed linens that looked like dried blood. -In room 324, the carpet, curtains, pillows and chairs were covered with unidentifiable stains. -The walls in room 324 were damaged with dark black scuff marks from the wheelchair hitting the walls. -The sink pipes in Room 324 were colored green and black specks from an enzymes cleaner. -The window sill in room 324 had mold in the corners and on the bottom of the window. -The window in room 324 would not close completely to prevent a breeze from coming in. -There were catheter items stored in a box on the floor and briefs stored on the floor in room 305. -There were strips over the tile in the entry to the shower to keep water from getting underneath the linoleum in room 305. -There were open cereal boxes stored underneath the sink in room 305. -The window sill in room 307 had mold. -The window in room 307 had water damage from being left opened. -The laundry room ceiling had circular brown water marks from a leak. -The refrigerator in room 203 needed defrosting. -The ceiling in room 203 had circular brown water marks on the ceiling from water damage from the bathroom on the 3rd floor. -There was food debris, and fabric fuzz on the carpet in room 203. -The mattress in room 203 had brownish looking feces and yellow urine stains. -There were sticky, brownish spills in the bottom of two medication carts. -The room door was damaged with scuffed black 	D 079		

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D 079	<p>Continued From page 12</p> <p>marks from the wheelchair in room 211.</p> <ul style="list-style-type: none"> -The ceilings in room 211 had circular brownish water damage from the 3rd floor. -There was a large live roach behind the chair in the short hall memory care unit sitting area. -There was a live roach in the memory care unit laundry room. -There were roach droppings by the light fixtures in the memory care unit dining room. -The mattress and mattress cover were torn and there were food particles in the bed in room 117. -A dried brownish substance in the bottom of the chair in room 117. <p>Interview with a second-floor resident reported:</p> <ul style="list-style-type: none"> -She killed 2 large roaches in the bathroom and one large roach by a family members picture. -The roaches would come out during the day and at night. -She did not recall a pest control company coming to spray the facility. -Housekeeping did not always clean the room twice week. -She had never seen housekeeping clean the refrigerator located in her room. -She could not recall the last time she let the housekeeper or other staff know about the roaches. <p>Interview with a housekeeper on 11/30/17 at 11:10 am revealed:</p> <ul style="list-style-type: none"> -They were assigned rooms to clean everyday. -Cleaning a room entailed puling the linens and trash, cleaning the sink, shower, commode and mopping, replacing clean linens, making the bed and vacuuming. -Roaches had been a problem for years. -Years ago they had a large flood and they had been a problem ever since. -The roach problem seemed to be getting better. 	D 079		

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NAME OF PROVIDER OR SUPPLIER BROOKDALE COTSWOLD	STREET ADDRESS, CITY, STATE, ZIP CODE 3610 RANDOLPH ROAD CHARLOTTE, NC 28211
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D 079	<p>Continued From page 13</p> <ul style="list-style-type: none"> -She deep cleaned two rooms a day. -The deep cleaning included dusting the blinds, cleaning windows, walls, baseboards, walls and doorframes. -The refrigerators were cleaned as needed. -The staff turnover had been an issue. -It was a very large building and once she was finished cleaning one side the other was already in need of cleaning. <p>Confidential staff interview on 12/1/17 revealed:</p> <ul style="list-style-type: none"> -Housekeepers rotated to clean the memory care unit. -The staff on the memory care unit made-up the beds. -The housekeepers were supposed to change the bed linen weekly, but memory care staff usually changed the linen prior to a resident's scheduled cleaning day. -The staff were supposed to make sure that there were no food particles in the residents' beds before making beds up. -The facility had major problems with roaches. -The roaches were in the memory care refrigerator so bad, the refrigerator needed to be replaced a few months ago. -The microwave was supposed to be replaced because roaches were in the inside of the microwave, but the facility continued to have staff use the microwave. -The staff had seen roaches coming out of the microwave in the memory care unit kitchen when staff picked the microwave up. <p>Confidential interview with a housekeeper on 12/1/17 revealed:</p> <ul style="list-style-type: none"> -She was responsible for cleaning rooms and washing linens. -The housekeepers would sometimes assist with making beds. 	D 079		

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D 079	<p>Continued From page 14</p> <ul style="list-style-type: none"> -She was recently told in the stand-up meeting to write down how long it took to clean a room. -She kept a note pad on the cleaning cart to write down information related to problems she observed while cleaning. -She would never leave a bed that was soiled or had food particles in the bed unchanged. <p>_____</p> <p>The facilities failure to maintain the building in an uncluttered, clean, orderly manner, free of hazards in the Memory Care dining room and kitchen, the 3rd floor laundry, the 3rd floor spa/bathroom and 15 of the resident's rooms with carpet stains, food crumbs, dirty toilets, stained mattresses, including room 212 with roach infested furniture whereby the roaches crawled on one resident residing in room 212 adversely effecting her sleep. These failures were detrimental to the health and safety of the residents which constitutes a TYPE B VIOLATION.</p> <p>_____</p> <p>Review of the facility's Plan of Protection dated 12/01/17 revealed:</p> <ul style="list-style-type: none"> -A pest control company would be called to treat the entire building. -The sheet would be changed in rooms #324, #117, and #110A. -The microwave will be bagged, sealed and discarded from the Memory Care Kitchenette. -A monthly pest control company will the kitchen and affected rooms on 12/01/17. -The mattresses in rooms #324, #203, #103, #110A, and #117 will be replaced with a new mattresses. -A moisture proof mattress cover will be placed on all new mattresses. -The recliner from room #103 will be cleaned. -The RCC or designee will inspect the rooms noted in the Health Department Report weekly 	D 079		

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D 079	Continued From page 15 and random checks of the other rooms and areas will be checked weekly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 18, 2018.	D 079		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that 2 of 6 sampled staff were competency validated for Licensed Health Professional Support (LHPS) tasks of finger stick blood sugars (FSBS) (Staff D) and indwelling urinary catheter care (Staff E). The findings are: A. Review of Resident #4's current FL2 dated 10/16/17 revealed: -Diagnoses included Type 2 Diabetes. -There was a physician's order to perform FSBS	D 161		

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D 161	<p>Continued From page 16</p> <p>every AM before breakfast and every PM before dinner.</p> <p>Review of Resident #4's Resident Register revealed an admission date of 03/23/15.</p> <p>Review of Resident #4's LHPS evaluation dated 08/14/17 revealed documentation that staff were to perform FSBS for her.</p> <p>-Review of Resident #4's Medication Administration Records (MAR) for October 2017 and November 2017 revealed Staff E documented FSBS on 10/17/17, 10/18/17, 10/20/17, 10/21/17, 10/22/17, 10/24/17, 10/25/17, 10/26/17, 10/27/17, 10/30/17, 10/31/17, 11/02/17, 11/04/17, 11/05/17, 11/06/17, 11/07/17, 11/08/17, 11/09/17, 11/10/17, 11/13/17, 11/14/17, 11/15/17, 11/16/17, 11/18/17, 11/19/17, 11/21/17, 11/22/17, 11/23/17, 11/24/17, and 11/27/17.</p> <p>Review of Staff E's personnel file revealed: -She was hired as a Medication Aide (MA) on 09/17/17. -There was no documentation of a completed LHPS competency validation.</p> <p>Interview on 12/01/17 at 2:05 pm with Staff E revealed: -She had been employed at this facility since mid-September 2017. -She was hired as a MA for the Special Care Unit (SCU) section of the facility. -Her job duties included obtaining FSBS. -She recalled being competency validated with return demonstration by a Registered Nurse (RN), but it was sometime after she had begun working independently to care for residents at this facility.</p>	D 161		

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D 161	<p>Continued From page 17</p> <p>Refer to interview on 12/01/17 at 1:50 pm with the SCU Resident Care Coordinator (RCC).</p> <p>Refer to telephone interview on 12/04/17 at 9:22 am with the Assisted Living (AL) RCC.</p> <p>Refer to interview on 12/01/17 at 2:07 pm with the Wellness Director (WD).</p> <p>Refer to interview on 12/01/17 at 12:50 pm with the Executive Director (ED).</p> <p>B. Review of Resident #3's current FL2 dated 02/22/17 revealed diagnoses included hydronephrosis (swelling of the kidney due to a build-up of urine) and over active bladder.</p> <p>Review of Resident #3's Resident Register revealed an admission date of 11/15/13.</p> <p>Review of Resident #3's LHPS evaluation dated 09/12/17 revealed documentation that Resident #3 was to receive staff assistance with positioning and emptying of her urinary catheter bag and cleaning around the catheter.</p> <p>Interview with Resident #3 on 11/29/17 at 2:46 pm revealed she had an indwelling urinary catheter that staff were responsible for providing care for.</p> <p>Review of Staff D's personnel file revealed: -She was hired as an MA on 10/17/17. -There was no documentation of a completed LHPS competency validation.</p> <p>Telephone interview on 12/04/17 at 9:28 am with Staff D revealed: -She had been employed at this facility since mid-October 2017.</p>	D 161		

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D 161	<p>Continued From page 18</p> <ul style="list-style-type: none"> -She had been hired as a MA for the AL section of the facility. -Her job duties included performing catheter care. -She recalled being competency validated by an RN, but it was sometime after she had begun working independently to care for residents at this facility. -She recalled performing return demonstration of FSBS, insulin administration and urinary catheter care. <p>Refer to interview on 12/01/17 at 1:50 pm with the SCU RCC.</p> <p>Refer to telephone interview on 12/04/17 at 9:22 am with the AL RCC.</p> <p>Refer to interview on 12/01/17 at 2:07 pm with the WD.</p> <p>Refer to interview on 12/01/17 at 12:50 pm with the Administrator/ED.</p> <p>_____ Interview on 12/01/17 at 1:50 pm with the SCU RCC revealed:</p> <ul style="list-style-type: none"> -She had been employed as the SCU RCC for 10 months. -She was responsible for completing the staff schedule for the entire facility. -She would schedule new staff once they had completed 3 days of online training and 3 days of shadowing of another staff member. -The facility's RN was responsible for performing competency validations on new staff. -She was unaware staff had to be competency validated prior to performing tasks independently. <p>Telephone interview on 12/04/17 at 9:22 am with the AL RCC revealed:</p> <ul style="list-style-type: none"> -She had been employed as the AL RCC for 2 	D 161		

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D 161	<p>Continued From page 19</p> <p>months.</p> <ul style="list-style-type: none"> -The SCU RCC was responsible for completing the staff schedule for the entire facility, but she would fill in any gaps in coverage on the AL side when needed. -She was aware new staff had to be competency validated prior to performing tasks independently. -The WD would notify her whenever a new staff person had completed all training requirements and was ready to be added to the schedule. -She had been notified that Staff D was to be added to the schedule after she had completed 3 days of online training and 3-4 days of shadowing another staff member so she was unaware staff D was not validated. <p>Interview on 12/01/17 at 2:07 pm with the WD revealed:</p> <ul style="list-style-type: none"> -She had been employed at this facility for 2 months. -The SCU RCC was responsible for completing the staff schedule for the entire facility with the help of the AL RCC. -The facility's RN was responsible for performing competency validations on new staff. -The RN no longer worked for the facility as of August 2017. -A new RN had taken the position in October 2017 and would be responsible for performing competency validations on staff once her training was complete. -She was unable to locate the LHPS competency validations for Staff D and Staff E. -She was unsure as to whether Staff D and Staff E had been competency validated for tasks being performed. <p>Interview on 12/01/17 at 12:50 pm with the Administrator/ED revealed:</p> <ul style="list-style-type: none"> -There was a RN who did all of the LHPS 	D 161		

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D 161	Continued From page 20 competency validations for staff. -The LHPS Nurse came in once a week and made sure all of the staff members were checked off on the LHPS tasks. -The LHPS Nurse kept a spread sheet of all of the staff who completed the mandatory training with the date and staff signature documented on the spread sheet. -A copy of the LHPS competency validation was placed in the staff file. -He was unable to locate the LHPS competency validations for any of the staff members. -It was his expectation the LHPS Nurse was to check every new staff member off during their 3 day orientation when they first began working at the facility. -Starting 01/01/18 there would be a new training schedule in place and all staff would have all of the mandatory training completed by February 2018.	D 161		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way	D 167		

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D 167	<p>Continued From page 21</p> <p>valve pocket mask for use in performing cardio-pulmonary resuscitation.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 19 of 60 days (Staff E) on second shift and 2 of 60 days (Staff F) on third shift from 10/1/17-11/30/17.</p> <p>The findings are:</p> <p>A. Review of Staff E's personnel file revealed: -Staff E was hired as a MA on 10/24/11. -She worked on 2nd shift. -There was no documentation of Staff F's CPR certification which expired on 07/30/17.</p> <p>Review of the staffing schedule dated 10/01/17 - 11/30/17 revealed: -Staff E's name was in red and this denoted she was the designated CPR certified staff member for 2nd shift. -There were 19 out of the 60 second shift's left uncovered by a staff member certified in CPR.</p> <p>B. Review of Staff F's personnel file revealed: -Staff F was hired as a Medication Aide (MA) on 9/16/03. -She worked 3rd shift. -There was no documentation of Staff F's CPR certification which expired on 06/30/17.</p> <p>Review of the staffing schedule dated 10/01/17 - 11/30/17 revealed: -Staff F's name was in red and this denoted she was the designated CPR certified staff member for 3rd shift.</p>	D 167		

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D 167	<p>Continued From page 22</p> <p>-There were 2 out of the 60 third shift's left uncovered by a staff member certified in CPR.</p> <p>Interview with the Wellness Director (WD) on 12/01/17 at 1:10 pm revealed:</p> <p>-She had been the WD since October 2017.</p> <p>-She really did not know what the system was for ensuring one staff member was CPR certified on each shift every day.</p> <p>-They used to have a quality assurance nurse who kept track of the staff's CPR certification and she left in October [2017].</p> <p>-She did not know whose responsibility it was now to ensure one staff member was CPR certified on each shift every day.</p> <p>-There had not been an occasion in the last year in which a resident required the Heimlich maneuver or CPR.</p> <p>-The CPR certified employees' names were on the schedule in red.</p> <p>-She was not aware the employees' names in red on the schedule for second and third had expired CPR certifications.</p> <p>Interview with the Business Office Manager on 12/01/17 at 1:23 pm revealed:</p> <p>-The corporation had a spreadsheet they used in other communities to keep track of CPR and other staffing requirements but the spreadsheet had not been implemented in this facility as of yet.</p> <p>-She was responsible for storing the CPR certifications in the employee files but did not have a process in place to know who all had CPR and when the CPR certification expired.</p> <p>-She was still in training and most of her training has centered around accounts payable and receivable.</p> <p>-She had been introduced to everything she would have to keep track of but had not undergone the training for staff qualifications.</p>	D 167		

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D 167	Continued From page 23 -She was not aware the employees' designated on the schedule as having CPR certifications.	D 167		
D 375	<p>10A NCAC 13F .1005(a) Self-Administration Of Medications</p> <p>10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 1 sampled resident (Resident #1) had a physician's order for self-administration of medication after being readmitted to the facility following a 7 day hospitalization for a temporary loss of consciousness due to a severe infection and also failed to assure all medications for 1 of 1 sampled residents (Resident #1) were properly labeled resulting in the Resident#1 self-administering trazodone 100 mg every morning at 8 am when the order was for trazodone 100 mg every evening.</p> <p>The findings are:</p>	D 375		

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D 375	<p>Continued From page 24</p> <p>A. Review of Resident #1's FL2 dated 2/21/17 revealed: -Diagnoses included Parkinson's, hypertension, insomnia, depression, arterial stenosis, and a murmur. -An order for Resident #1 to self-administer all medications.</p> <p>Review of Resident #1's hospital discharge summary dated 11/27/17 revealed: -Diagnoses included syncope (a temporary loss of consciousness) due to sepsis (a severe infection) secondary to a urinary tract infection, Parkinson's, hypertension, insomnia, depression, arterial stenosis, and a murmur. -She was admitted to the hospital on 11/22/17. -There was no order to self-administer medications.</p> <p>Interview on 11/29/17 with Resident #1 at 9:28 am revealed: -She returned to the facility on 11/27/17 after a hospital admission on 11/22/17 - 11/27/17. -She took her own medications according to the directions on the packets. -She was able to describe what her medications were used for but could not recall the names of all of her medications. -The pharmacy sent all of her medications over in a monthly dispense box. -The Medication Aides (MAs) checked on her to see if her medications were taken every day on their morning and night medication passes. -She was not aware of any changes in her medications except for a new antibiotic. -She continued to take her medications where she left off after her hospitalization starting on 11/28/17 with the 11/22/17 pre-packaged medications.</p>	D 375		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060132	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2017
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NAME OF PROVIDER OR SUPPLIER BROOKDALE COTSWOLD	STREET ADDRESS, CITY, STATE, ZIP CODE 3610 RANDOLPH ROAD CHARLOTTE, NC 28211
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D 375	<p>Continued From page 25</p> <ul style="list-style-type: none"> -The staff did not talk to her about her medication changes when she was readmitted to the facility. -The MA told her about one new medication ceftin (a medication used to treat infection) was added to her daily medications and that she would take the ceftin for 10 days. -She was not aware there were other medications changed including a new medication, temazepam 30 mg at bedtime (a medication used to treat insomnia symptoms) and the trazodone (a medication used to treat insomnia) was discontinued. -She was also unaware of new orders for Kenalog cream (a steroid cream for the skin) Traxene (a medication used to treat anxiety). -The WD only asked how she was doing after she returned from the hospital. <p>Review of the Self Administration Medication Review form revealed:</p> <ul style="list-style-type: none"> -The form was dated 8/03/17. -Resident #1 was documented as fully capable of stating what each medication was and used for, the time the medication was to be taken, and dosage. -There was no change documented on previous assessments. -It was done quarterly and signed by a Registered Nurse (RN). -There was not a Self-Administration Medication Review form filled out after Resident #1 was readmitted after her hospitalization on 11/27/17. <p>Interview on 11/29/17 with the Wellness Director (WD) at 3:24 pm revealed:</p> <ul style="list-style-type: none"> -She did not call the physician and get the order to continue the self-administration of her medications -When the medications come in from the pharmacy for Resident #1, the medications were 	D 375		

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D 375	<p>Continued From page 26</p> <p>given to the resident.</p> <p>-The medications from the pharmacy were not checked for accuracy against the physician orders.</p> <p>-Residents who self-administer do not get the "chart or cart audits" because they are responsible for taking their own medications.</p> <p>-Residents that self-administer medications were reassessed after significant changes in their conditions and hospitalizations.</p> <p>-She checked Resident #1's "cognitive capabilities" of taking medications after Resident #1 was readmitted after her hospitalization but did not do the Self Administration Medication Review assessment form.</p> <p>Interview on 11/29/17 with the Assisted Living Resident Care Coordinator (AL RCC) at 4:02 pm revealed:</p> <p>-She was hired by the facility 4-5 months ago as the RCC.</p> <p>-Resident #1 was readmitted to the facility after returning from the hospital on 11/27/17.</p> <p>-She was not aware of a new self-administration order renewed by the physician.</p> <p>-She was aware Resident #1 was hospitalized for syncope, altered mental status and sepsis and considered that a significant change in Resident #1.</p> <p>-She did not readmit Resident #1 in after returning from the hospital.</p> <p>-The WD was responsible for reassessing a resident who was considered a "self-administrator" quarterly, with significant changes and with readmissions as well as getting the new order to self-administer.</p> <p>Interview on 11/30/17 with a MA at 12:40 pm revealed:</p> <p>-She was hired by the facility 2 months ago as a</p>	D 375		

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D 375	<p>Continued From page 27</p> <p>MA.</p> <ul style="list-style-type: none"> -She readmitted Resident #1 after arriving from the hospital. -She was not aware of a "new order tracking sheet". -She faxed all the new orders to the pharmacy, did vital signs, entered new physician orders, documented orders on the eMAR and placed the record in the hot box for 72 hours so the MAs could watch for any changes in the resident. -The WD was responsible for clarifying all of the orders in the readmit packet after returning from the hospital as well as the reassessment for a resident who self-administers. -She gave the WD the readmit packet for Resident #1 for clarification of the orders. <p>Telephone interview 11/30/17 with the Pharmacy at 2:26 pm revealed:</p> <ul style="list-style-type: none"> -She was a pharmacist. -She did not receive a new order for Resident #1 to self-administer her medications. -The last time Resident #1's medications were filled was 11/21/17 with a start date of 11/24/17 to 12/21/17, a 14 day supply. -Any changes to Resident #1's medication required the facility to bring back the unused medication pre-filled packets for the pharmacy to refill with the changes in medications added. <p>Interview on 11/30/17 with the Administrator/Executive Director (ED) at 3:40 pm revealed:</p> <ul style="list-style-type: none"> -Resident #1 required a self-administer assessment and physician's order after readmission after the hospitalization. -A resident that was considered "self-administration" with their medications was to have their medications checked against the orders for accuracy by the WD. 	D 375		

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D 375	<p>Continued From page 28</p> <p>-He was not aware a self-administer assessment was not completed by the WD once Resident #1 was readmitted after her hospitalization.</p> <p>-The eMAR was to be checked to make sure the resident was taking their medications, refusals and accuracy by the WD.</p> <p>-He was not aware WD was not doing the cart or record audits with Resident #1.</p> <p>Telephone interview on 12/01/17 with Resident #1's physician's Medical Office Assistant (MOA) revealed:</p> <p>-The physician considered Resident #1's hospital admission for syncope, altered mental status, and sepsis, an significant change in Resident #1 and should have prompted in a reassessment of Resident #1's capabilities of self-administration and a new order for Resident #1 to self-administer.</p> <p>-There was no order written by the physician to self-administer medications since Resident #1 returned from the hospital on 11/27/17.</p> <p>-There was no assessment form the facility for self-administer of medications completed on Resident #1 since readmission after returning from the hospital on 11/27/17.</p> <p>B. Review of Resident #1's record revealed a current FL2 dated 2/21/17 revealed:</p> <p>-Diagnoses included Parkinson's Disease, hypertension, insomnia, depression, arterial stenosis, and a murmur.</p> <p>-An order for trazodone 100 mg at bedtime (a medication used for depression that causes drowsiness).</p> <p>-An order for Resident #1 to self-administer all medications.</p> <p>Observation on 11/29/17 during initial tour at 9:28 am revealed:</p>	D 375		

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D 375	<p>Continued From page 29</p> <ul style="list-style-type: none"> -Resident #1 was taking her 8:00 am pre-packaged medications. -There were 3 empty packets with an 8:00 am dose time, and with the medications contents listed on each packet as followed; packet 1/3 dated 11/23/17: trazodone 100 mg x 1, and 4 other medications. <p>Interview on 11/29/17 with Resident #1 at 9:28 am revealed:</p> <ul style="list-style-type: none"> -She returned to the facility on 11/27/17 after a hospitalization from 11/22/17 through 11/27/17. -She took her own medications according to the directions on the packets. -Once a month the pharmacy sent all of her medications over in a monthly dispense box. -There were 3, 8:00 am pre-filled dose packets to be taken every morning. -Each of the pre-packaged dose packs were labeled with the medication contents. -The Medication Aides (MA) would ask her if she had taken her medication. -She continued to take her medications where she left off before she was hospitalized starting on 11/28/17 with the 11/22/17 pre-packaged medications. -She was not aware prior to the hospitalization she was supposed to take her trazodone at night rather than 8:00 am. -She was not aware after her hospitalization the trazodone had been discontinued. <p>Telephone interview on 11/30/17 with Resident #1's family member at 12:00 pm revealed:</p> <ul style="list-style-type: none"> -There were problems with the facility administering Resident #1 medications as prescribed since she was admitted to the facility in 2013. -A year ago he asked the physician if Resident #1 could "self-administer" her own medications and 	D 375		

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D 375	<p>Continued From page 30</p> <p>was told yes.</p> <p>-He felt that since Resident #1 was admitted to the hospital for sepsis and was there for 7 days, Resident #1 may need to be reassessed because she may not "remember well".</p> <p>-He had a pharmacy that received all of Resident #1's physician's orders and filled the medications so Resident #1 could self-administer them.</p> <p>-He was not aware trazodone was not labeled to be given at the correct time.</p> <p>-It was his understanding and expectation that Resident #1 medications were checked for accuracy of medication, route, time and quantity and the nurse to evaluate her if there was a change in her abilities.</p> <p>Interview on 11/29/17 with a MA at 9:39 am revealed:</p> <p>-Resident #1 self-administered her own medications.</p> <p>-Resident #1 would let the MAs know when her medications were low and needed a refill.</p> <p>-She checked with Resident #1 every morning when she did the medication pass to verify if Resident #1 took the medications.</p> <p>-Resident #1 returned from the hospital on 11/27/17 sometime after 2 pm and she did not re-admit Resident #1.</p> <p>Review of Resident #1's November 2017 electronic Medication Administration Record (eMAR) revealed an order for trazodone 100 mg at bedtime was documented as "self-administered" 11/01/17 at 9:00 pm - 11/28/17 at 9:00 pm.</p> <p>Interview on 11/29/17 with the Wellness Director (WD) at 3:24 pm revealed:</p> <p>-When the medications come in from the pharmacy for Resident #1, the medications were</p>	D 375		

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D 375	<p>Continued From page 31</p> <p>given to the resident.</p> <p>-The medications from the pharmacy were not checked for accuracy against the eMAR or physician orders.</p> <p>-Residents that self-administer do not get the "chart or cart audits" because they are responsible for taking their own medications.</p> <p>-The facility was responsible for procuring Resident #1's medications and sending them back to the pharmacy for repackaging.</p> <p>Interview on 11/29/17 with the Assisted Living Resident Care Coordinator (AL RCC) at 4:02 pm revealed:</p> <p>-She was hired by the facility 4-5 months ago as the RCC.</p> <p>-Resident #1 was readmitted to the facility after returning from the hospital on 11/27/17.</p> <p>-She did not readmit Resident #1 in after returning from the hospital.</p> <p>-She was not aware the resident was taking the trazodone at the wrong time.</p> <p>Interview on 11/30/17 with a MA at 12:40 pm revealed:</p> <p>-She was hired by the facility 2 months ago as a MA.</p> <p>-She readmitted Resident #1 to the facility after arriving from the hospital.</p> <p>-She was not aware of a "new order tracking sheet".</p> <p>-She faxed all the new orders to the pharmacy, did vital signs, entered new orders for medications and discontinued medications on the eMAR and placed the record in the hot box for 72 hours so the MAs could watch for any changes in the resident.</p> <p>-She faxed the new orders to the physician per policy for any changes and inform the physician of the new orders from the hospital.</p>	D 375		

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D 375	<p>Continued From page 32</p> <p>-All residents who return from the hospital were to be reported to the WD and she let the WD know about the return of Resident #1 after all of the paperwork was done.</p> <p>-The WD was responsible for changes in the medications with all of the self-administer residents.</p> <p>-She did not check the current eMAR with the continued, new or discontinued orders from the hospital.</p> <p>-She did not check the medication labels on the new medications against the new orders.</p> <p>-She was not aware the resident was taking the trazodone at the wrong time.</p> <p>Telephone interview 11/30/17 with the Pharmacy at 2:26 pm revealed:</p> <p>-She was a pharmacist.</p> <p>-They did not have the discharge summary dated 11/27/17 that ultimately discontinued the trazodone.</p> <p>-The refill order on file dated 08/26/17 for trazodone 100 mg once daily.</p> <p>-The refill order had "daily" on the escript so the trazodone was put in to be administered at 8 am and there was no documentation where the ordered was clarified with the physician on the order.</p> <p>-The last time Resident #1's medications were filled was 11/21/17 with a start date of 11/24/17 to 12/21/17, a 14 day supply which included the trazodone.</p> <p>-Any changes to Resident #1's medication required the facility to bring back the unused medication pre-filled packets for the pharmacy to refill with the changes in medications added as well as times reprinted or corrected on the label.</p> <p>Interview on 11/30/17 with the Administrator/Executive Director (ED) at 3:40 pm</p>	D 375		

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D 375	<p>Continued From page 33</p> <p>revealed:</p> <ul style="list-style-type: none"> -When Resident #1 was readmitted after returning from the hospital, the RCCs, MAs or the WD should have gone over the hospital discharge instructions with Resident #1 to make sure Resident #1 was informed about new or changed orders. -The WD would have verified all of Resident #1 medications with the Hospital Discharge Summary orders to make sure all of the medications the resident was taken were correct. -A resident that was considered "self-administration" with their medications was to have their medications checked against the orders for accuracy by the WD -The eMAR was to be checked to make sure the resident was taking their medications, refusals and accuracy by the WD. -He was not aware WD was not doing the record "audits" with Resident #1. <p>Interview on 11/30/17 with WD at 4:00 pm revealed:</p> <ul style="list-style-type: none"> -She did not speak to Resident #1 about the changes in the medications the resident took daily after Resident #1 was readmitted after her hospitalization. -Resident #1 had a change in her medications with the discontinuation of 3 medications and that required her medications to be sent back to the pharmacy for repackaging. -Resident #1's medications were not returned to the pharmacy for removal of the medications that were discontinued when Resident #1 was discharged from the hospital or to have the medications re-packaged with the new orders or correction in the time administered. -She was not aware the trazodone label instructions were to take the medication at 8:00 am instead of the nightly ordered time on the FL2 	D 375		

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D 375	Continued From page 34 dated 2/21/17. -She did record and cart audits on other residents but not resident that are "self-administration". Telephone interview on 12/01/17 with Resident #1's physician's Medical Office Assistant revealed: -The facility called 11/29/17 to clarify the administration time of the trazodone order of 8:00 pm versus the administration time on the label being 8:00 am. -The order for trazodone 100 mg every night was still active in Resident #1 records at their office. -The physician's expectation was for the staff to check all eMARs against the orders to check for accuracy and to make sure a resident who was self-administering was taking their medications correctly and accurately.	D 375		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8	D 463		

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D 463	<p>Continued From page 35</p> <p>and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 3 of 4 sampled residents (#2, #6 and #7) admitted to the Special Care Unit had a pre-admission screening and disclosure information completed and documented in the resident record.</p> <p>The findings are:</p> <p>1. Review of Resident #2's current FL-2 dated 6/28/17 revealed: -Diagnoses included dementia, hyperlipidemia, osteoarthritis, emphysema, and osteoporosis. -Memory Care was the recommended level of care.</p> <p>Review of Resident #2's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) on 6/9/17.</p> <p>Review of Resident #2's record revealed there was no pre-admission screening or disclosure completed on admission to SCU.</p> <p>Refer to interview with the Special Care Unit Resident Care Coordinator (SCU RCC) on 11/30/17 at 4:00 pm.</p> <p>Refer to interview with the Wellness Director (WD) on 12/1/17 at 8:45 pm.</p> <p>Refer to interview with the Administrator/Executive Director (ED) on 12/1/17</p>	D 463		

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D 463	<p>Continued From page 36</p> <p>at 9:15 am.</p> <p>2. Review of Resident #6's current FL-2 dated 3/31/17 revealed: -Diagnoses included dementia, mild hypertension, history of falls, and low back pain. -Memory Care was the recommended level of care.</p> <p>Review of Resident #6's Resident Register revealed the resident was admitted to the SCU on 4/2/17.</p> <p>Review of Resident #6's record revealed there was no pre-admission screening or disclosure completed on admission to SCU.</p> <p>Refer to interview with the Special Care Unit Resident Care Coordinator (SCU RCC) on 11/30/17 at 4:00 pm.</p> <p>Refer to interview with the Wellness Director (WD) on 12/1/17 at 8:45 pm.</p> <p>Refer to interview with the Administrator/Executive Director (ED) on 12/1/17 at 9:15 am.</p> <p>3. Review of Resident #7's current FI-2 dated 6/30/17 revealed: -Diagnoses included hypertension, hyperlipidemia, anxiety, and early onset dementia. -Memory Care was the recommended level of care.</p> <p>Review of Resident #7's Resident Register revealed the resident was admitted to the SCU on 7/3/17.</p>	D 463		

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NAME OF PROVIDER OR SUPPLIER BROOKDALE COTSWOLD	STREET ADDRESS, CITY, STATE, ZIP CODE 3610 RANDOLPH ROAD CHARLOTTE, NC 28211
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D 463	<p>Continued From page 37</p> <p>Review of Resident #7's record revealed there was no pre-admission screening or disclosure completed on admission.</p> <p>Refer to interview with the Special Care Unit Resident Care Coordinator (SCU RCC) on 11/30/17 at 4:00 pm.</p> <p>Refer to interview with the Wellness Director (WD) on 12/1/17 at 8:45 pm.</p> <p>Refer to interview with the Administrator/Executive Director (ED) on 12/1/17 at 9:15 am.</p> <p>Interview with Special Care Unit Resident Care Coordinator (SCU RCC) for the memory care unit on 11/30/17 at 4pm revealed: -She had been employed as the SCU RCC for 10 months. -She was not aware a pre-screening was required prior to being admitted into SCU. -She was not aware disclosure information was required be provided to the family prior to resident being admitted. -The Wellness Director (WD) was responsible for completing all forms at admission. -She would assist the WD at times, but only completed forms that were in the admission packet provided by the WD. -The pre-screening form/disclosure information was not included in the admission packet.</p> <p>Interview with the Wellness Director (WD) on 12/1/17 at 8:45 am revealed: -She had been employed as the WD for 4 months. -She was responsible for completing admission forms for all new residents in the facility. -The current admission packet was provided by a</p>	D 463		

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D 463	<p>Continued From page 38</p> <p>sister facility that does not have a SCU. -She was not aware disclosure information had to be provided and a pre-screening was required prior to residents being admitted to the SCU.</p> <p>Interview with the Administrator on 12/1/17 at 9:15 am revealed: -He had been employed at the facility for 4 days. -He was aware of the pre-screening form and disclosure information required prior to admission. -He was not aware they had not been completed for some of the residents in the SCU. -He expected the disclosure information to be completed by himself or Business Office Manager(BOM) upon move-in. -He expected the WD or SCU RCC to complete the pre-screening form prior to admission. -He was not sure why the pre-screening form/disclosure information was not completed but he assured going forward staff would be completing the forms.</p>	D 463		
D 468	<p>10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train</p> <p>10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training</p> <p>The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and</p>	D 468		

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D 468	<p>Continued From page 39</p> <p>schedules regarding training achievement.</p> <p>(2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents.</p> <p>(3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.</p> <p>(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that 1 of 3 sampled staff (Staff E) assigned to perform duties in the special care unit (SCU) received 6 hours of orientation training within the first week of employment and 1 of 3 sampled staff (Staff A) received 20 hours of training within six months of employment.</p> <p>The findings are:</p> <p>1. Review of Staff E's personnel file revealed: -Staff E was hired as a Medication Aide (MA) on 9/17/17. -Staff E completed 3 hours of SCU orientation training on 9/18/17. -There was no documentation of any other training specific to the SCU population within the first week of hire, from 9/17/17 through 9/24/17.</p>	D 468		

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D 468	<p>Continued From page 40</p> <p>Interview on 12/1/17 at 2:10 pm with Staff E revealed: -She worked in the SCU during 2nd shift and functioned as a MA. -She provided personal care, supervision, and administered medications to the residents in the SCU. -She had previous experience working in the SCU at another facility. -She completed several hours of computer based training as requested by the facility during the first week of hire which included training specific to dementia. -She was unaware that she needed to have 6 hours of dementia specific training within the first week of hire. -She was unaware the staff of the SCU involved with personal care and supervision were required to have 20 hours of training in the first 6 months of hire. -She had not had any additional training at this facility since her first week of hire.</p> <p>Refer to interview with the Special Care Unit Resident Care Coordinator (SCU RCC) on 12/1/17 at 1:15 pm.</p> <p>Refer to interview with the Wellness Director (WD) on 12/1/17 at 1:40 pm revealed:</p> <p>Refer to interview Executive Director (ED) on 12/1/17 1:50 pm.</p> <p>2. Review of Staff A's personnel file revealed: -Staff A was hired as a Medication Aide (MA) on 10/4/16. -Staff A completed 6 hours of Special Care Unit (SCU) orientation training upon hire. -There was no documentation of any other</p>	D 468		

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D 468	<p>Continued From page 41</p> <p>training specific to the SCU population within 6 months of hire, from 10/4/16-3/4/17.</p> <p>Interview on 12/1/17 at 12:55 pm with Staff A revealed:</p> <ul style="list-style-type: none"> -She worked in the SCU as a MA for 1 year and 2 months. -She provided personal care and administered medications to the residents in the SCU. -She did not remember how much dementia training she had taken. -She remembered when she was hired, she completed computer based training related to the SCU population and an in-service with the previous SCU RCC. -She was unaware the staff of the SCU involved with personal care and supervision were required to have 20 hours of training in the first 6 months of hire. -She did not know how many hours of training she had but the facility offered frequent in-service and computer-based training's but they were not always based on the SCU population. <p>Refer to interview with the Special Care Unit Resident Care Coordinator (SCU RCC) on 12/1/17 at 1:15 pm.</p> <p>Refer to interview with the Wellness Director (WD) on 12/1/17 at 1:40 pm revealed:</p> <p>Refer to interview Executive Director (ED) on 12/1/17 1:50 pm.</p> <p>Interview on 12/1/17 at 1:15 pm with the RCC revealed:</p> <ul style="list-style-type: none"> -She was aware staff needed 6 hours of dementia related training within the first week of being hired and 20 hours of dementia related training within the next six months of employment. 	D 468		

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D 468	<p>Continued From page 42</p> <ul style="list-style-type: none"> -The Special Care Director (SCD) who was currently on leave was responsible for completing training for new employees who would work in the SCU. -She was aware staff were not receiving the required training upon hire and ongoing for the SCU. -She had asked the previous ED and current WD when the SCD went on leave if she could assure the new hire training requirements in the SCU were met and was informed an area special care representative would be responsible for completing training. <p>Interview with the WD on 12/1/17 at 1:40 pm revealed:</p> <ul style="list-style-type: none"> -She was aware staff working in the SCU unit needed dementia related training, which included 6 hours within the first week and 20 hours within the next 6 months. -The training was previously completed by the SCD who was currently on leave. -She was unaware of which staff had been trained by the SCD and if a log was kept. -The training had not been completed for those scheduled due to staffing being "horrible" and the need to have staff working. <p>Interview on with the Executive Director (ED) on 12/1/17 at 1:50 pm revealed:</p> <ul style="list-style-type: none"> -He had only worked at the facility for 4 days. -He expected the Business Office Manager (BOM) to ensure the first 6 hours of training related to the SCU was completed with staff. -He expected the SCU RCC or WD to ensure the additional 20 hours of training was completed with staff working in the SCU within 6 months of being hired. -He was aware of the SCU training requirements. -He was not aware some of the SCU staff had not 	D 468		

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D 468	Continued From page 43 completed the required training.	D 468		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration.</p> <p>The findings are:</p> <p>Based on observations, interviews, and record reviews, the facility failed to maintain the building, in a clean and orderly manner, free of all, hazards as related to the Speciality Care Unit (SCU) kitchenette, the 3rd floor laundry and spa and 15 residents rooms with carpet stains, food crumbs, dirty toilets, stained mattress and live roaches throughout the facility. [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation).]</p>	D912		