Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034026	A. BUILDING: _____ B. WING _____	03/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF WINSTON SALEM	2601 REYNOLDA ROAD WINSTON SALEM, NC 27106

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 6 - 8, 2019 and on March 11, 2019.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 3 of 6 sampled staff (Staff C, D, and F) were tested for tuberculosis (TB) disease with the two-step skin test in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Staff C, medication aide's (MA) personnel record revealed: -Staff C was hired on 08/08/14. -There was documentation Staff C had a negative tuberculosis (TB) skin test read on 09/21/14. -There was documentation Staff C had a second TB skin test on 10/02/14; the second TB skin test was not read. Interview with the Business Office Manager	D 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nilsa Aquino Rivera Nilsa A Rivera — TITLE: Executive Director — (X6) DATE: 4/23/19

Reviewed and accepted 5/17/19 Jo Scarlett

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(BOM) on 03/11/19 at 1:12pm revealed she had not noticed Staff C's second TB skin test did not have a read date.

Interview with the Executive Director on 03/11/19 at 1:40pm revealed she did not know Staff C did not have her second TB skin test read.

Attempted interview with Staff C on 03/11/19 at 11:04am was unsuccessful.

Refer to interview with the BOM on 03/11/19 at 1:12pm.

Refer to interview with the ED on 03/11/19 at 1:40pm.

2. Review of Staff D, medication aide's (MA) personnel record revealed:
-Staff D was hired on 05/17/18.
-There was documentation Staff D had a negative tuberculosis (TB) skin test read on 05/24/18.
-There was no documentation Staff D had a second TB skin test.

Interview with Staff D on 03/11/19 at 10:42am revealed:
-She started working in the first week of June 2018.
-She had a TB test prior to working at the facility; she did not recall if she had a second TB skin test.
-She did not recall if anyone had told her she needed a second TB skin test.

Interview with the Business Office Manager (BOM) on 03/11/19 at 1:12pm revealed she had not noticed Staff D did not have a second TB skin test.

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D 131	Continued From page 2 Interview with the Executive Director on 03/11/19 at 1:40pm revealed she did not know Staff D did not have a second TB skin test. Refer to interview with the BOM on 03/11/19 at 1:12pm. Refer to interview with the ED on 03/11/19 at 1:40pm. 3. Review of Staff F, cook's personnel record revealed: -Staff F was hired on 05/10/16. -There was documentation Staff F had a negative tuberculosis (TB) skin test read on 05/01/16. -There was no documentation Staff F had a second TB skin test. Interview with Staff F on 03/11/19 at 10:40am revealed: -She started working in 2016 as a cook. -She had a TB test prior to working at the facility. -She recalled having a second TB skin test when she was hired and turned it in the facility Business Office Manager. -She had not been told by anyone her second TB skin test was missing. Interview with the Business Office Manager (BOM) on 03/11/19 at 1:12pm revealed she had not noticed Staff F's second TB skin test was missing. Interview with the Executive Director (ED) on 03/11/19 at 1:40pm revealed she did not know Staff F did not have documentation for a second TB skin test. Refer to interview with the BOM on 03/11/19 at 1:12pm.	D 131		

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D 131	Continued From page 3 Refer to interview with the ED on 03/11/19 at 1:40pm. Interview with the Business Office Manager (BOM) on 03/11/19 at 1:12pm revealed: -She started working at the facility in May 2018. -She was responsible for personnel records. -Upon hire staff were told they had to obtain a two-step TB skin test. -The first TB skin test had to be completed prior to working in the facility. -The employee was responsible for obtaining the second TB skin test. -When information came in for personnel records she filed it in the employee's personnel records; she did not review the content of the information. -She had noticed there were things missing in the personnel records when staff would ask for a copy of something and it was not in their personnel record. -She started going through the personnel records about three months ago; she pulled out what was not needed and put items in the correct section. -She planned to have all personnel records audited and corrected by June 2019. Interview with the Executive Director (ED) 03/11/19 at 1:40pm revealed: -The BOM was responsible for personnel records. -She expected all required documents to be completed within the required time frame and filed in the personnel records.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home	D 137		

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D 137	Continued From page 4 shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to access the North Carolina Health Care Personnel Registry (HCPR) to assure 2 of 6 facility staff (Staff D and Staff F) had no substantiated findings listed on the HCPR. The findings are: 1. Review of Staff D, medication aide's (MA) personnel record revealed: -Staff D was hired on 05/17/18. -There was no documentation a Health Care Personnel Registry Check (HCPR) was completed. Interview with Staff D on 03/11/19 at 10:42am revealed: -She started working in the first week of June 2018. -She did not know if a HCPR check had been completed. Interview with the Business Office Manager (BOM) on 03/11/19 at 1:12pm revealed she had not noticed Staff D did not have a HCPR completed. Interview with the Executive Director (ED) on 03/11/19 at 1:40pm revealed she did not know Staff D did not have a HCPR completed. Refer to interview with the BOM on 03/11/19 at	D 137		

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1:12pm.

Refer to interview with the ED on 03/11/19 at 1:40pm.

Documentation of Staff D's HCPR check was provided prior to exit on 03/11/19.
2. Review of Staff F, cook's personnel record revealed:
-Staff F was hired on 05/10/16.
-There was no documentation a Health Care Personnel Registry Check (HCPR) was completed.

Interview with Staff F on 03/11/19 at 10:40am revealed:
-She started working in 2016 as a cook.
-She did not know if a HCPR check had been completed prior to her employment.

Interview with the Business Office Manager (BOM) on 03/11/19 at 1:12pm revealed she did not know Staff F needed a HCPR completed as a cook she thought only clinical staff needed it.

Interview with the Executive Director (ED) on 03/11/19 at 1:40pm revealed she did not know Staff F did not have a HCPR completed.

Refer to interview with the BOM on 03/11/19 at 1:12pm.

Refer to interview with the ED on 03/11/19 at 1:40pm.

Interview with the Business Office Manager (BOM) on 03/11/19 at 1:40pm revealed:
-She started working at the facility in May 2018.
-She was responsible for personnel records.
-She was responsible for completing a Health

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D 137	Continued From page 6 Care Personnel Registry Check (HCPR) on all staff. -She had noticed there were things missing in the personnel records when staff would ask for a copy of something and it was not in their personnel record. -She started going through the personnel records about three months ago; she pulled out what was not needed and put items in the correct section. -She planned to have all personnel records audited and corrected by June 2019. Interview with the Executive Director (ED) on 03/11/19 at 1:40pm revealed: -The BOM was responsible for personnel records. -She expected all required documents to be completed within the required time frame and filed in the personnel records.	D 137		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure hair nets were worn in the special care unit (SCU) kitchen while food was being served, as well as the facility failed to assure the kitchen and the SCU kitchen, walls, floors, and food storage areas were kept clean and free of contamination.	D 282		

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D 282	Continued From page 7 The findings are: Observations of the SCU kitchen on 03/07/19 at 8:38am revealed: -There were dried brown drip marks and splatter spots on the kitchen walls and doors. -There was a thick layer of dust built up on the walls behind the ice cream freezer, behind the beverage dispenser and along the wall between the two doors into the SCU kitchen area. Observation of the reach-in refrigerator in the SCU kitchen on 03/07/11 at 8:38am revealed: -The door gasket was covered with a dark brown build-up of grime. -The metal wire shelving had a build-up of a moist black substance. -The inside walls were streaked with dried brown and white substances. Observation of the ice and water dispenser in the SCU kitchen on 03/07/19 at 8:38am revealed there was standing water under the grate; the metal under the grate was brown and slimy. Observation of a small chest freezer in the SCU kitchen on 03/07/19 at 8:38am revealed: -There was a four-inch crack along the top of the door that prohibited the door from sealing when closed. -The inside of the freezer, used to store ice cream, was covered in a three-inch layer of ice. -There were three large containers of ice cream with crystallized ice inside the ice cream containers. Observation of a set of storage shelves in the SCU kitchen on 03/07/19 at 8:38am revealed: -There was a large set of metal shelves. -There were bags of cereal, condiments, and	D 282		

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containers holding silverware, cups, plates, hot chocolate, and syrup sitting on the shelves.
-The left side of the shelves was beside the trash can.
-The outside left edges were all coated in a dried black and brown grime.

Observation of a metal rolling prep table in the SCU kitchen on 03/07/19 at 8:38am revealed the legs of the table were covered in a build-up of grime and dirt.

Observation of the SCU kitchen floor on 03/07/19 at 8:38am revealed there were spots of a build-up of black dirt and grime under the storage shelves, under the metal rolling prep table, and around the trash can area.

Observation of the main kitchen area on 03/07/19 at 2:50pm revealed:
-There was a multi-tiered cart with trays of uncovered plated desserts inside the kitchen door; this area was open to facility staff walking through without hair nets.
-The floor under the steam table was covered in a build-up of dirt and grime, food particles and trash.
-The left side edge and front edges of the steam table had a build-up of a dark brown substance.
-Two of three steam wells had a dark brown sticky build-up.
-There were two large sets of storage shelves; the shelves were coated in a thick layer of grease and dust.
-The metal wall behind the gas stove range had a thick build-up of brown and black grease.
-The inside of the six burners on the gas stove range was covered with food debris and backed on grease.
-The flat top grill was covered in a dark brown

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and build-up.
-The flat top grill was between the gas stove range and deep fryer and shared a metal side wall; the metal side walls were covered in a thick build-up of grease on each side of the flat top grill.
-The inside of the condiment area of the sandwich prep table was covered in dried food particles.

Observation of the walk-in cooler/freezer in the main kitchen on 03/07/19 at 2:50pm revealed:
-The door gasket was covered with a dark brown build-up of grime.
-The floor under the shelving of the walk-in cooler and freezer was covered in trash and food debris.
-The ceiling inside the walk-in cooler was covered in a build-up of dust and grime.
-The shelving inside the walk-in cooler and freezer had a build-up of dirt and grime.
-There was a 2-feet by 4-feet area of the floor of the walk-in freezer that had a sticky black build-up.

Observation of the two ovens in the main kitchen on 03/07/19 at 2:50pm revealed:
-There was burnt food and black build-up inside both ovens.
-Both oven doors were covered in a dark yellow and sticky-build-up of grease.

Observation of the ice cream cooler in the main dining room on 03/06/19 at 2:48pm revealed the inside was covered in a three-inch layer of ice.

Observation of the SCU kitchen on 03/07/19 at 8:30am revealed multiple staff going in/out of the kitchen area without hair nets.

Interview with a dietary aide on 03/07/19 at

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D 282	Continued From page 10 8:30am revealed they did not have hair nets in the SCU kitchen. Interview with the Dietary Manager on 03/07/19 at 8:32am revealed: -They did not have hair nets in the SCU kitchen. -The dietary staff "always had hair nets on when they left the main kitchen and went into the SCU kitchen". -She had sent her staff to the main kitchen to bring hair nets to the SCU kitchen. Interview with a SCU personal care aide (PCA) on 03/07/19 at 9:15am revealed: -She was responsible for wiping down the steam table every night. -She thought dietary cleaned the steam table every day. -She thought housekeeping mopped every day. Observation of the SCU kitchen on 03/07/19 at 12:11pm revealed: -There was multiple staff going in and out of the kitchen without hair nets while the food was being served. -The dietary manager eventually told the staff not to come into the kitchen but to ask her for what they needed. Interview with the Dietary Manager on 03/07/19 at 3:32pm revealed: -She did not currently have a cleaning schedule; it had been a couple of months since she had used a cleaning schedule. -The kitchen was mopped every night by the cook. -Dietary staff had cleaned under the steam table "really good" at the beginning of February (She did not recall the date). -She had cleaned under the shelves in the	D 282		

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D 282	Continued From page 11 walk-in cooler/freezer last Tuesday; she had used a deck brush and cleaner to try to clean the build-up off the floor. -She had not noticed the dust build-up on the cooler ceiling; it had been cleaned last summer when they had work done on the cooler. -She had not noticed the dust build-up on the shelves; they tried to clean the shelves as needed. (She did not recall when they were cleaned but was "probably a couple of months ago"). -She assigned cleaning the shelves to a a dietary staff member who washed dishes or herself. -The shelves that held clean pots had been cleaned three to four months ago; she had taken the shelves outside and used hot water and degreaser to clean them. -The stove top/burners had been deep cleaned about four to six weeks ago. -She did not recall when the back or side of the griddle had been cleaned. -The steam table and wells were wiped down nightly by the cook; the steam wells are deep cleaned monthly to remove the build-up. (She did not recall when they were last deep cleaned). -The inside of the sandwich prep table was cleaned in December when it was repaired. -The walls beside the sandwich prep table were wiped down every day; the wall was missed today, but she knew it was wiped down because she had done it herself several times during the week. -The dietary cook cleaned the oven about 2 weeks ago; the oven had never been professionally cleaned. -The dietary cook did a lot of cleaning at night. -The gaskets to the cooler had been cleaned a couple of months ago. -She had moved everything out of the cooler and deep cleaned it in October 2018.	D 282		

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D 282	Continued From page 12 -She knew the kitchen needed to be deep cleaned, but she had staffing issues and had not had time. -Her staff was not responsible for cleaning the kitchen in the SCU; a couple of years ago it was turned over to the SCU staff. Interview with a dietary cook on 03/07/19 at 3:46pm revealed: -She worked second shift. -She was responsible for cleaning at night; she cleaned the floors, walls, oven, and steam table. -She cleaned the floor under the steam table, sprayed it with cleaner and let it set, recently (She was not sure the date). -She swept and mopped under the steam table every night. -She wiped the steam wells last night using a cleaning solution; she did not use a pad to clean the build-up off. -She had changed the oil in the deep fryer last week and when she pulled it out she cleaned the wall and sides of the griddle. Interview with the SCU Manager on 03/07/19 at 4:27pm revealed: -Dining service staff was in charge of the SCU kitchen; they were responsible for bringing food from the main kitchen, serving food, taking dirty dishes back to the kitchen, preparing the hydration table with juices, water, and coffee. -Housekeeping mopped the SCU kitchen daily. -The SCU staff cleaned the steam table area daily and wiped down surface areas. -The SCU staff were responsible for wiping under the grates in the ice/water machine. -She had not noticed there was a slimy build up; she expected it to be cleaned daily. -She thought the walls were the responsibility of the dietary and housekeeping staff.	D 282		

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D 282	Continued From page 13 -She thought the inside of the refrigerator would be the responsibility of the dietary staff; she had not noticed the build-up on the shelves. -The ice cream cooler was not being used; ice cream for the SCU residents came from the large ice cream cooler in the main dining room. -She had not noticed the shelves were dirty. -The SCU staff used the oven in the activity room and therefore would be responsible for cleaning it; she had not noticed it had not been cleaned. Interview with a SCU housekeeper on 03/08/19 at 10:14am revealed: -She had been working at the facility for a month. -She mopped the SCU kitchen every Friday. -She did not wipe anything off in the SCU kitchen. -She did not do anything with the oven in the SCU activity room. Interview with a PCA on 03/08/19 at 10:17am revealed: -She swept the SCU kitchen every day. -She wiped off the tops of the steam table after meals. -She had never worn a hair net in the SCU kitchen until today (03/08/19). Interview with a second PCA on 03/08/19 at 10:24am revealed: -She wiped off the top of the steam table area daily. -She swept after every meal. -She had not cleaned the shelves in the refrigerator. -She had not worn hair nets in the SCU kitchen; no one told her she needed to. Interview with a third PCA on 03/08/19 at 10:27am revealed: -She had worn a hair net before in the SCU	D 282		

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kitchen; she did not wear one every day.
-No one had ever told her she needed to wear a hair net in the SCU kitchen.
-She cleaned the SCU kitchen area when she worked including wiping down the steam wells, lids, counter space, microwave area, coffee, and tea machines and wiping under the grate on the ice/water machine.
-She swept the kitchen every day; housekeeping was responsible for mopping.

Interview with a dietary aide on 03/08/19 at 11:13am revealed she was responsible for cleaning the main kitchen beverage area and the dining room.

Interview with the Dietary Manager on 03/08/19 at 4:40pm revealed:
-The dietary aide was responsible for cleaning of the ice cream freezer.
-The ice cream freezer was defrosted weekly.
-It was defrosted about two weeks ago; they missed a week because of all the rain.
-She thought the dietary aides did a good job keeping the ice cream freezer clean.

Interview with a dietary aide on 03/08/19 at 4:43pm revealed:
-She took all the ice cream out of the freezer and defrosted it.
-She defrosted the freezer about two weeks ago.
-If everyone would keep the door closed the ice would not build up as fast.

Interview with the Executive Director on 03/07/19 at 3:59pm revealed:
-She had a meeting set up with the facilities regional dietary manager to get a better understanding of dietary services.
-She had not made rounds in the kitchen; she

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D 282	Continued From page 15 had been in the kitchen area only casually. -She was not aware of uncovered food stored in an area where staff was walking in and out without hair nets. -She was not aware of the floor under the prep table/steam table. -She was not aware of the dirt and grease build up on the steam table, wells, stove, oven, flat top griddle, shelving, cooler ceiling, floors, and shelving, cooler/freezer floors and cooler/freezer shelves. -She expected dietary services to have a cleaning schedule. -Dining service staff was responsible for cleaning the kitchen. -She was not aware the SCU did not have hair nets available to be worn by staff. -She was not aware the SCU ice cream cooler walls, floors, doors, refrigerator, ice and water dispenser needed to be cleaned. -She thought the SCU kitchen would be cleaned and maintained by the kitchen staff and SCU staff.	D 282		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or	D 344		

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D 344	Continued From page 16 clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 2 of 7 sampled residents (Resident #4) regarding antibiotics and (Resident #5) regarding an order for blood thinner, pain reliever, and nebulizer treatment. The findings are: Review of Resident #5's current FL2 dated 02/20/19 revealed: -Diagnoses included Alzheimer's disease, dementia without behaviors, hypertension, stroke, and atrial fibrillation. -There was no order for Aspirin 81mg daily (used to help prevent blood clots due to Atrial Fibrillation). -There was no order for Albuterol (used to treat bronchospasm) 0.63mg/3ml give 1 vial via inhalation every 6 hours as needed for wheezing. -There was no order for acetaminophen (pain reliever) 500mg every 6 hours as needed for pain. Review of Resident #5's physician's order dated 08/14/18 revealed: -There was an order for Aspirin 81mg daily. -There was an order for Albuterol 0.63mg/3ml give 1 vial via inhalation every 6 hours as needed	D 344		

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for wheezing.
-There was an order for acetaminophen 500mg every 6 hours as needed for pain.

Review of Resident #5's February and March 2019 MAR revealed:
-There was an entry for Aspirin 81mg daily.
-There was an entry for Albuterol 0.63mg/3ml give 1 vial via inhalation every 6 hours as needed for wheezing.
-There was an entry for acetaminophen 500mg every 6 hours as needed for pain.
-Aspirin was documented as administered daily from 02/01/19 through 03/06/19.
-Albuterol was not documented as administered 02/01/19 through 03/06/19.
-Acetaminophen was not documented as administered 02/01/19 through 03/06/19.

Review of Resident #5's record revealed:
-There was no documentation Resident #5's provider had been contacted to clarify the orders for Aspirin, Albuterol, and acetaminophen which had been left off the FL2 dated 02/20/19.

Interview with a medication aide (MA) on 03/11/19 at 11:55 am revealed:
-She had administered medications to Resident #5.
-She did not know medications had been left off the FL2 for Resident #5
-Medication aides did not audit charts.
-Medication aides did not audit FL2's.
-Orders were copied and put in a binder for the medication aides to review.
-Medication aides completed monthly cart audits to ensure sure all medications on the MAR's are on the medication cart.

Interview with a wellness nurse on 03/11/19 at

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D 344	Continued From page 18 12:00 pm revealed: -She did not know medications had been left off the FL2 for Resident #5. -The Resident Care Director (RCD) completed annual FL2's. -The RCD worked on completing Resident #5's FL2. -The part-time wellness nurse completed a lot of the FL2's for the RCD. -She had never completed an FL2. -When orders were received, whoever (RCD or wellness nurses) was there took care of them by transcribing the order onto the MAR and faxing the order to the pharmacy. Interview with the RCD on 03/11/19 at 12:15 pm revealed: -She did not know medications had been left off the FL2 for Resident #5. -The part-time wellness nurse was responsible for completing the FL2's and physicians order sheets. -All nurses were allowed to complete FL2's if needed. -We review a printout of medications then attach it to or transcribe the orders to the new FL2. -We then fax it to the prescribing practitioner and ask them to review and sign. -She did not know how or why the medications were left off of Resident #5's FL2. -They compared the old FL2's and physicians orders to the new FL2 as well as looked through the record for order changes. -She expected the FL2's to be completed correctly. Interview with the Executive Director on 03/11/19 at 12:29 pm revealed: -She did not know about medications being left off of Resident #5's FL2.	D 344		

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D 344	Continued From page 19 -She expected all FL2's to be filled out correctly and thoroughly. Interview with the Prescribing Practitioner on 03/11/19 at 10:45 am revealed: -He did not know there had been medications left off the FL2 for Resident #5. -He wanted the resident to continue taking Aspirin, Albuterol, and acetaminophen. -The information on the FL2 should be reviewed prior to sending to him to be signed. -He and the facility should have been more diligent in their review of the FL2. -He expected the FL2's and all orders to be transcribed correctly and completely prior to them being sent to him for his signature. 2. Review of Resident #4's current FL2 dated 04/26/18 revealed diagnoses included cerebral infarction, dysphagia, hypertension, hyperlipidemia, hemiplegia, Gastroesophageal Reflux Disorder, Parkinson's, muscle weakness, an dementia. Review of subsequent physician's orders revealed: -There was an order dated 01/09/19 for fosfomycin (an antibiotic used to treat urinary tract infections) 3 gram packet once. -There was an order dated 01/09/19 for fosfomycin 3 gram packet weekly from 01/17/19 to 2/14/19. -There was an order dated 01/23/19 for fosfomycin 3 gram packet weekly for urinary tract infection signed by the physician's assistant (PA). Review of Resident #4's January Medication Administration Record (MAR) revealed: -Fosfomycin 3 grams one packet for a one time order documented as administered on 01/10/19	D 344		

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at 8:00am.
-Fosfomycin 3 grams one packet for a weekly order documented as administered on 01/10/19 at 8:00am.
-Fosfomycin 3 grams one packet weekly documented as administered on 01/17/19, 01/24/19, 01/25/19, and 01/31/19.

Review of Resident #4's February MAR revealed fosfomycin 3 grams one packet weekly documented as administered on 02/01/19, 02/07/19, 02/08/19, 02/14/19, and 02/22/19.

Interview with a wellness nurse on 03/07/19 at 3:36 pm revealed:
-The wellness nurses are responsible for transcribing the PA orders into the computer MAR and faxing the order to the pharmacy.
-The wellness nurses look over the PA orders and if there are any questions they call for clarification of the orders.
-She had never did a record review on any resident.

Interview with a wellness nurse on 03/08/19 at 11:55am revealed:
-She did not know Resident #4 was ordered fosfomycin 3 gram packet weekly on 01/09/19 and on 01/23/19
-She did not know Resident #4's MAR had documentation of fosfomycin 3 gram packet administered on Thursday and Friday from 01/24/19 to 02/15/19.
-She did not know Resident #4's MAR had an order on 01/10/19 for fosfomycin 3 gram packet once and another order for 01/10/19 both at 8:00am.
-The wellness nurse who entered the 01/23/19 fosfomycin 3 gram packet weekly order should have seen there was already a weekly order for

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the same medication on Resident #4's MAR.
-The wellness nurse who received the order on 01/23/19 for fosfomycin 3 gram packet weekly should have contacted the PA for clarification.
-The wellness nurses document clarification of orders they receive from the PA and put it in the computer system and the resident chart.

Interview with the Resident care Director (RCD) on 03/07/19 at 4:06pm revealed:
-She expected all resident record reviews to be completed monthly by the wellness nurses during their resident wellness visit.
-She expected during the record review the wellness nurses would look at everything including PA orders and the medications.
-She expected if the wellness nurses found an error they would let her know.
-She expected if the wellness nurses found an error they would call the PA or would have communicated for her to contact the PA for clarification of an order.
-She expected the wellness nurses to have noticed that Resident #4 had fosfomycin 3 gram packet weekly on the MAR before entering the order again on another day.
-She did not know Resident #4's MAR had fosfomycin 3 gram packet on Thursday and on Friday from 01/23/19 to 02/14/19.

Telephone interview with the pharmacist at the contract pharmacy on 03/08/19 at 10:39am revealed:
-There was one packet of fosfomycin 3 gram packet sent on 01/09/19.
-There were four packets of fosfomycin 3 gram packet sent on 01/23/19.
-There were three packets of fosfomycin 3 gram packet sent on 02/14/19.
-Medication orders were faxed from the facility to

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the pharmacy.
-The pharmacy sent the medications based on the orders faxed to the pharmacy.
-The pharmacy did not have access to the facility MAR's.

Interview with the medication aide (MA) on 03/08/19 at 11:46am revealed:
-She was only able to see what medications were to be given on her shift.
-She did not know she had administered Resident #4's fosfomycin on Thursday's weekly and another MA was documenting administering fosfomycin weekly on Friday's.
-She should have looked closer at the orders and asked the wellness nurses for any clarification.

Telephone interview with the physician's assistant (PA) on 03/11/19 at 10:18am revealed:
-He ordered Resident #4 fosfomycin 3 gram packet once weekly on 01/23/19 for a urinary tract infection.
-He had been told the hospital physician ordered the medication but the facility did not have the prescription.
-He only wrote the order on 01/23/19 for Resident #4's fosfomycin 3 gram packet once weekly because he was told by the facility it was recommended by the hospital physician at discharge.
-Resident #$ was to be administered fosfomycin 3 gram packet once weekly.
-He did not know fosfomycin 3 gram packet was ordered for Resident #4 on Thursday and Friday from 01/24/19 to 02/15/19.

Interview with the Executive Director (ED) on 03/08/19 at 3:28pm revealed:
-She did not know the Resident #4's fosfomycin that was ordered for once a week was on the

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D 344	Continued From page 23 MAR on Thursday and Friday from 01/24/19 to 02/15/19. -She did not know that Resident #4's fosfomycin was not clarified by the wellness nurses, or the RCD. -She expected that the wellness nurse would have seen the same medication being ordered weekly and would have contacted the PA for clarification. -She expected that the duplicate fosfomycin order would have been seen during a record review. -She expected the wellness nurse team to conduct record reviews monthly or bi-monthly.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION	D 358		

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D 358	Continued From page 24 Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (#2, #3, and #4) related medications not discontinued or changed from scheduled to as needed after a hospital discharge (#2), Coumadin not being held for a resident (#3) with an international normalized ratio (INR) of 4.99, and an antibiotic ordered weekly for 5 weeks, reordered for weekly, and administered 2 times in one day and 2 times a week for 3 weeks (#4). The findings are: 1. Review of Resident #3's current FL-2 dated 11/19/18 revealed: -Diagnoses included chronic atrial fibrillation, dementia, diabetes, hyperlipidemia, gout, hypertension, and end stage renal disease. -There was an order for Coumadin 2mg daily in the afternoon. (Coumadin is a blood thinner). Review of Resident #3's physician's order for dated 01/22/19 was to alternate Coumadin 3mg and 5mg every other day. Review of Resident #3's physician' order dated 01/30/19 revealed an order to hold Coumadin for two days and recheck INR on 01/31/19. Review of Resident #3's electronic medication administration record (eMAR) for January 2019 revealed: -There was an entry for Coumadin 3mg every other day with administration scheduled at 4:30pm. -There was a second entry for Coumadin 5mg every other day with administration scheduled at 4:30pm.	D 358		

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-Coumadin 5mg was documented as administered at 4:30pm on 01/30/19.
-Coumadin 3mg was documented as administered at 4:30pm on 01/31/19.

Review of Resident #3's physician' order dated 02/01/19 revealed an order to hold Coumadin on 02/01/19 and 02/02/19 and restart 2.5mg daily on 02/03/19.

Review of Resident #3's eMAR for February 2019 revealed:
-There was an entry for Coumadin 3mg every other day with administration scheduled at 4:30pm; the order was discontinued on 02/01/19.
-There was a second entry for Coumadin 5mg every other day with administration scheduled at 4:30pm; the order was discontinued on 02/01/19.
-Coumadin was not documented as administered on 02/01/19 or 02/01/19.

Review of the facility's Coumadin tracking log for Resident #2 revealed:
-There was documentation Resident #3's international normalized ratio (INR) on 01/29/19 was 4.99 (above therapeutic range); new order for Coumadin was to hold.
-Next INR draw date was documented as 01/31/19.
-There was documentation Resident #3's INR on 01/31/19 was 4.19 (above therapeutic range); new order for Coumadin was to hold for 02/01/19 and 02/02/19.

Telephone interview on 03/08/19 at 11:27am with a nurse at the dialysis clinic revealed:
-Resident #3's INR on 01/29/19 was 4.99.
-The medication order was to hold Coumadin for two days and recheck INR.
-INR was rechecked on 01/31/19 with a result of

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D 358	Continued From page 26 4.18. -The medication order was to hold Coumadin on 02/01/19 and 02/02/19 and restart Coumadin 2.5mg daily with a start date of 02/03/19. Telephone interview with a representative from the facility's contracted pharmacy on 03/08/19 at 11:43am revealed: -On 01/16/19 they had received an order for Resident #3 to take 5mg Coumadin every other day; the medication was started on 01/17/19 and stopped on 01/29/19. -Resident #3 may have already had 3mg tablets to be administered on the alternate days. -The next order they received for Resident #3 for Coumadin was dated 02/12/19 for 2.5mg daily. -They had filled multiple doses of Coumadin for Resident #3 as it changed based on his needs. Interview with the medication aide (MA) on 03/08/19 at 3:43pm revealed: -The Wellness Nurse usually notified the MA's verbally of any medication changes. -If she saw something new in the system that she had not been told about she would ask the wellness nurse. -If a medication was to be held the eMAR would have not allowed the medication to be administered; the eMAR system would not have alerted the MA that medication was scheduled to be administered. -She administered Resident #3's Coumadin on 01/30/19 and 01/31/19. -She did not know Resident #3's Coumadin was supposed to be held on 01/30/19 and 01/31/19. -If Resident #3's Coumadin had been held on 01/30/19 and 01/31/19 she would not have administered the medication. Interview with a Wellness Nurse on 03/08/19 at	D 358		

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D 358	Continued From page 27 12:23pm revealed: -She was not responsible for Coumadin medication changes but would receive order changes if the other wellness nurse was not available. -When a new order came in she would transcribe it into the eMAR. -She would discontinue any current Coumadin orders and enter the new Coumadin order. -She would write a note in the resident's record with what the result was. -She would fax a copy to the pharmacy, stamp the copy and put it in the PCP's binder. -She would update the Coumadin log. Telephone interview with a second Wellness Nurse on 03/08/19 at 12:39pm revealed: -The Wellness Nurses put all medication orders in the eMAR -Resident #3 had his INR labs drawn on Tuesday when he was at the dialysis clinic. -She would call the clinic on Wednesday afternoon if she had not received the results and any changes in orders. -Some of the nurses from the dialysis clinic would send an order change but it depended on the nurse. -She would update the Coumadin log and fax the change to the pharmacy. -She would update the dosage on the eMAR if there were any changes. -She usually always worked on Wednesdays, so she would be the one to receive the lab values and order changes. -Her log reflected what the order they received. -She recalled receiving an order to hold Resident #3's Coumadin (she did not recall the dates). -She would put a hold on the medication in the eMAR.	D 358		

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D 358	Continued From page 28 Interview with the same wellness nurse on 03/11/19 at 1:30pm revealed: -She made the Coumadin log based on the orders she was given. -She would not have put any information into the log if she did not have an order. -She did not know why the orders were not filed in Resident #3's chart for Coumadin. -If Resident #3's Coumadin was scheduled to be held she would have put it on hold in the eMAR. -She did not know why the Coumadin was not held on 01/30/19 and 01/31/19; she was human and could have made a mistake. Interview with the Resident Care Director on 03/08/19 at 3:51pm revealed: -The Wellness Nurse was responsible for updating the Coumadin log based on new orders received. -The Wellness Nurse would update any Coumadin changes in the eMAR. -She was concerned Resident #3 was administered Coumadin when there was an order to hold it for 01/30/19 and 01/31/19 because it could be very dangerous. -If the wellness nurse had put the Coumadin on hold in the eMAR the system would have put an "X" on the date it was to be held and the MA's would have not been able to administer the medication. Telephone interview with a nurse at the dialysis clinic on 03/08/19 at 4:08pm revealed: -The doctor for Resident #3 was very concerned Resident #3's Coumadin orders were not being followed. -He was especially concerned on 01/29/19 when Resident #3's INR was so high and the Coumadin not being held because Resident #3 could bleed to death..	D 358		

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-When Resident #3's INR was repeated and it was still high he had called the facility to make sure the Coumadin was being held and was assured him that it had been.
-He expected the staff to follow the Coumadin orders.

Interview with the Executive Director on 03/08/19 at 4:48pm revealed:
-She was not aware there had been any errors with Resident #3's Coumadin.
-She expected Resident #3's Coumadin to be administered as ordered and for staff to clarify the order if needed.
-She was concerned Resident #3's Coumadin was not administered as ordered.

2. Review of Resident #2's current FL2 dated 08/22/18 revealed diagnoses included Alzheimer's disease with behavior disturbances, anxiety, and depression.

Review of Resident #2's Resident Register revealed an admission date of 08/30/18.

a. Review of Resident #2's physician' order dated 10/10/18 revealed an order for tramadol (used to treat mild to moderate pain) 50 mg tablet take one-half tablet (25mg) three times a day for pain.

Review of Resident #2's February 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Tramadol 25 mg three times a day scheduled for administration at 7:00am, 2:00pm and 7:00pm.
-Tramadol 25 mg was documented as administered 3 times a day from 02/01/19 to 02/21/19 at 7:00am.
-Resident #2 was documented as hospitalized

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from 02/21/19 to 02/28/19; no tramadol was documented as administered from 02/21/19 at 2:00pm to 02/28/19 at 7:00pm.

Review of Resident #2's recent hospital discharge summary dated 03/02/19 revealed an order to discontinue tramadol 25 mg three times a day. Review of Resident #2's medication orders generated at discharge dated 03/02/19 revealed tramadol 25 mg was no included in the new medication orders.

Review of Resident #2's March 2019 eMAR revealed:
-There was an entry for tramadol 50 mg give one-half tablet (25 mg) three times a day for pain.
-Tramadol 50 mg one-half tablet was documented as not administered from 03/01/19 at 7:00am to 03/02/19 at 7:00am due to resident "hospitalized".
-Tramadol 50 mg one-half tablet was documented as administered from 03/02/19 to 03/07/19 at 2:00pm.
-There were 12 doses of tramadol 25 mg administered after the order was discontinued on 03/02/19.

Interview with the Resident Care Director (RCD) on 03/07/19 at 4:06pm revealed:
-She did not know Resident #2 was receiving tramadol 25 mg scheduled subsequent to the discharge summary order on 03/02/19 to discontinue the medication.
-She expected all resident record reviews to be completed monthly by the wellness nurses during their resident wellness visit.
-She expected during the record review the wellness nurses would look at everything including PA orders, MARs, discharge summaries, and the medications.

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D 358	Continued From page 31 -Resident #2 had not had a monthly review since the hospital discharge 03/02/19. Telephone interview with a pharmacist at the contract pharmacy on 03/08/19 at 11:30am revealed: -The facility was responsible to enter medication orders into the eMAR system. -The pharmacy did not receive the hospital discharge summary for Resident #2 dated 03/02/19 with the order to discontinue tramadol 50 mg one-half tablet 3 times a day. -The pharmacy received eleven medication orders written on 03/02/19 for Resident #2 at discharge from the hospital but there was not an order for tramadol included with the new orders. Interview with a medication aide (MA) on 03/08/19 at 12:35am revealed: -The facility's wellness nurses were responsible to enter medication orders into the eMAR system. -MA did not routinely have access to residents' medication orders. -MAs were responsible to administer medications as they appeared on the eMAR. -She did not know Resident #2's tramadol was discontinued on 03/02/19. -She administered scheduled tramadol doses during her shift because the medication appeared on the eMAR at scheduled times. Interview with the RCD on 03/08/19 at 3:30pm revealed: -Resident #2 was discharged from the hospital and returned to the facility on a weekend. -There was a wellness nurse working each shift who was responsible for comparing residents' discharge medications orders to medications prior to hospitalization, discontinuing medications according to orders, and faxing new medication	D 358		

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orders to the contract pharmacy.
-From Monday to Friday, the wellness nurse had a second wellness nurse or the RCD double check orders entered into the eMAR system for accuracy.
-The facility did not have a system in place to double check orders entered on the weekend by the wellness nurse.

Telephone interview with a wellness nurse on 03/08/19 at 3:34pm revealed:
-She worked when Resident #2 returned from the hospital.
-She recalled processing Resident #2's medication orders on 03/02/19.
-She recalled she entered the order to discontinue tramadol 25 mg three times a day into the eMAR system.
-She did not know Resident #2's eMAR still listed tramadol 50 mg one-half tablet three times a day for pain with scheduled administration.
-She did not know why the eMAR system did not update Resident #2's tramadol to be discontinued.
-She did not have a system in place to recheck residents' eMARs for medication orders subsequent to orders entered on the weekend.

Telephone interview with Resident #2's physician assistant (PA) on 03/08/19 at 4:30pm revealed:
-He had reviewed Resident #2's hospital discharge summary on 03/04/19 or 03/05/19.
-He had not written an order to change Resident #2's tramadol from discontinued.
-He thought Resident #2 should be receiving tramadol 25 mg up to three times a day if he acted like he was in pain.
-He had no documentation regarding facility staff requesting tramadol to be restarted for Resident #2 prior to earlier in the day on 03/08/19.

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D 358	Continued From page 33 Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. b. Review of Resident #2's physician's order dated 10/10/18 revealed an order for acetaminophen 500 mg (used to treat mild pain) one tablet three times a day for pain. Review of Resident #2's February 2019 electronic medication administration record (eMAR) revealed: -There was an entry for acetaminophen 500 mg three times a day scheduled for administration at 7:00am, 2:00pm and 7:00pm. -Acetaminophen 500 mg was documented as administered 3 times a day from 02/01/19 to 02/21/19 at 7:00am. -Resident #2 was documented as hospitalized from 02/21/19 to 02/28/19; no acetaminophen was documented as administered from 02/21/19 at 2:00pm to 02/28/19 at 7:00pm. Review of Resident #2's recent hospital discharge summary for major neurocognitive disorder and behavior disturbance dated 03/02/19 revealed an order to change acetaminophen 500 mg three times a day scheduled to acetaminophen 500 mg three times a day, as needed for pain. There was a prescription order dated 03/02/19 for acetaminophen 500 mg three times a day, as needed for pain, included with the hospital discharge summary. Review of Resident #2's March 2019 eMAR revealed: -There was an entry for acetaminophen 500 mg three times a day scheduled for administration at 7:00am, 2:00pm and 7:00pm.	D 358		

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D 358	Continued From page 34 - Acetaminophen 500 mg was documented as not administered from 03/01/19 at 7:00am to 03/02/19 at 7:00am due to resident "hospitalized". -Acetaminophen 500 mg was documented as administered 3 times a day, at 7:00am, 2:00pm and 7:00pm, from 03/02/19 to 03/07/19 at 2:00pm. -There was no entry for acetaminophen 500 mg three times a day as needed for pain -There were 12 doses of acetaminophen 500 mg three times a day administered on scheduled times after the order was changed to "as needed" on 03/02/19. Observation of medication on hand for administration for Resident #2 revealed there was a bingo card with fifty-six doses of acetaminophen 500 mg dispensed on 03/02/19 for sixty tablets with instructions for one tablet 3 times daily as needed for pain. Interview with the Resident Care Director (RCD) on 03/07/19 at 4:06pm revealed: -She did not know Resident #2 was receiving acetaminophen 500 mg scheduled subsequent to the discharge summary order on 03/02/19 to change the medication to as needed. -She expected all resident record reviews to be completed monthly by the wellness nurses during their resident wellness visit. -She expected during the record review the wellness nurses would look at everything including PA orders, MARs, discharge summaries, and the medications. -Resident #2 had not had a monthly review since the hospital discharge 03/02/19. Telephone interview with a pharmacist at the contract pharmacy on 03/08/19 at 11:30am revealed:	D 358		

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D 358	Continued From page 35 -The facility was responsible to enter medication orders into the eMAR system. -The pharmacy did not discontinue a medication from the eMAR unless an order was received to discontinue the medication. -The pharmacy did not receive Resident #2's hospital discharge summary dated 03/02/19. -The pharmacy received 11 medication orders written on 03/02/19 for Resident #2 at hospital discharge. -There was an order for acetaminophen 500 mg one tablet 3 times a day, as needed for pain dated 03/02/19 included in the orders faxed to the pharmacy by the facility. -On 03/02/19, the pharmacy sent sixty tablets of acetaminophen 500 mg labeled one tablet 3 times a day, as needed for pain. Interview with a medication aide (MA) on 03/08/19 at 12:35am revealed: -The facility's wellness nurses were responsible to enter medication orders into the eMAR system. -MA did not routinely have access to residents' medication orders. -MAs were responsible to administer medications as they appeared on the eMAR. -She did not know Resident #2's acetaminophen 500 mg was changed from one tablet 3 times a day (scheduled for pain to one tablet 3 times a day, as needed for pain on 03/02/19. -She administered scheduled acetaminophen 500 mg doses during her shift because the medication appeared on the eMAR at scheduled times. Interview with the RCD on 03/08/19 at 3:30pm revealed: -Resident #2 was discharged from the hospital and returned to the facility on a weekend. -There was a wellness nurse working each shift	D 358		

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who was responsible for comparing residents' discharge medications orders to medications prior to hospitalization, discontinuing medications according to orders, and faxing new medication orders to the contract pharmacy.
-From Monday to Friday, the wellness nurse had a second wellness nurse or the RCD double check orders entered into the eMAR system for accuracy.
-The facility did not have a system in place to double check orders entered on the weekend by the wellness nurse.

Telephone interview with a wellness nurse on 03/08/19 at 3:34pm revealed:
-She worked when Resident #2 returned from the hospital.
-She recalled processing Resident #2's medication orders on 03/02/19.
-She recalled she entered the order to change Resident #2's acetaminophen 500 mg to 3 times a day, as needed.
-She did not know Resident #2's eMAR still listed acetaminophen 500 mg to 3 times a day three times a day for pain with scheduled administration.
-She did not know why the eMAR system did not update Resident #2's acetaminophen 500 mg.
-She did not have a system in place to recheck residents' eMARs for medication orders subsequent to orders entered on the weekend.

Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable.

c. Review of Resident #2's physician's order from a local hospice agency dated 12/27/18 revealed an order for compounded medication ABH Plo Gel 1/12.5/1 mg per milliliter (used topically for

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agitation) apply one milliliter topically every 6 hours as needed for agitation.

Review of Resident #2's recent hospital discharge summary dated 03/02/19 revealed ABH Plo Gel 1/12.5/1 mg per milliliter was not listed on medications to be continued and no new medication order was included in the medications prescriptions written on 03/02/19.

Review of Resident #2's March 2019 eMAR revealed:
-There was an entry for ABH Plo Gel 1/12.5/1 mg per milliliter (used topically for agitation) apply on milliliter topically every 6 hours as needed for agitation.
- ABH Plo Gel 1/12.5/1 mg per milliliter (used topically for agitation) apply on milliliter topically every 6 hours as needed for agitation was documented as administered one dose on 03/07/19 at 1:00pm.

Observation of medication on hand for administration for Resident #2 revealed there were 53 doses of ABH Plo Gel 1/12.5/1 mg per milliliter available.

Interview with the Resident Care Director (RCD) on 03/07/19 at 4:06pm revealed:
-She expected all resident record reviews to be completed monthly by the wellness nurses during their resident wellness visit.
-She expected during the record review the wellness nurses would look at everything including PA orders, discharge summaries, MARs, and the medications.
-Resident #2 had not had a monthly review since the hospital discharge 03/02/19.

Telephone interview with a pharmacist at the

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contract pharmacy on 03/08/19 at 11:30am revealed:
-The facility was responsible to enter medication orders into the eMAR system.
-The pharmacy did not discontinue a medication from the eMAR unless an order was received to discontinue the medication.
-The pharmacy did not receive Resident #2's hospital discharge summary dated 03/02/19.
-The pharmacy received 11 medication orders written on 03/02/19 for Resident #2 at hospital discharge.
-The pharmacy did not dispense Resident #2's ABH Plo Gel 1/12.5/1 mg per milliliter from the contacted site and he was unable to verify a date and quantity dispensed for the medication.
-The facility should contact the hospice or primary care provider regarding continuing ABH Plo Gel 1/12.5/1 mg per milliliter.

Interview with a medication aide (MA) on 03/08/19 at 12:35am revealed:
-The facility's wellness nurses were responsible to enter medication orders into the eMAR system.
-The MA did not routinely have access to residents' medication orders.
-MAs were responsible to administer medications as they appeared on the eMAR.
-She did not know there was not a current order for ABH Plo Gel 1/12.5/1 mg per milliliter apply one milliliter topically every 6 hours as needed for agitation.
-She administered an ABH Plo Gel 1/12.5/1 mg per milliliter as needed for agitation during her shift on 03/07/19 because the medication appeared on the eMAR and the resident seemed to be agitated during a family member visit.

Interview with the RCD on 03/08/19 at 3:30pm revealed:

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	HAL034026	A. BUILDING: _____ B. WING _____	03/11/2019

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BRIGHTON GARDENS OF WINSTON SALEM	2601 REYNOLDA ROAD WINSTON SALEM, NC 27106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 39 -Resident #2 was discharged from the hospital and returned to the facility on a weekend. -There was a wellness nurse working each shift who was responsible for comparing residents' discharge medications orders to medications prior to hospitalization, discontinuing medications according to orders, and faxing new medication orders to the contract pharmacy. -From Monday to Friday, the wellness nurse had a second wellness nurse or the RCD double check orders entered into the eMAR system for accuracy. -The facility did not have a system in place to double check orders entered on the weekend by the wellness nurse. Telephone interview with a wellness nurse on 03/08/19 at 3:34pm revealed: -She worked when Resident #2 returned from the hospital. -She recalled processing Resident #2's medication orders on 03/02/19. -She recalled she entered the order to discontinue ABH Plo Gel 1/12.5/1 mg per milliliter apply on milliliter topically every 6 hours as needed for agitation into the eMAR system. -She did not know Resident #2's eMAR still listed ABH Plo Gel 1/12.5/1 mg per milliliter apply on milliliter topically every 6 hours as needed for agitation for administration. -She did not know why the eMAR system did not update to discontinue Resident #2's ABH Plo Gel 1/12.5/1 mg per milliliter apply on milliliter topically every 6 hours as needed for agitation. -She did not have a system in place to recheck residents' eMARs for medication orders subsequent to orders entered on the weekend. Telephone interview with Resident #2's physician assistant (PA) on 03/08/19 at 4:30pm revealed:	D 358		

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D 358	Continued From page 40 -He had reviewed Resident #2's hospital discharge summary on 03/04/19 or 03/05/19 and signed the discharge summary. Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. 3. Review of Resident #4's current FL2 dated 04/26/18 revealed diagnoses included cerebral infraction, dysphagia, hypertension, hyperlipidemia, hemiplegia, GERD, Parkinson's, muscle weakness, dementia, and hemiplegia. Review of subsequent physician's orders for Resident #4 revealed: -There was a physician order dated 01/09/19 for fosfomycin (an antibiotic used to treat urinary tract infections) 3 gram packet once. -There was a physician order dated 01/09/19 for fosfomycin 3 gram packet weekly from 01/17/19 to 02/14/19. -There was a physician assistant (PA) order dated 01/23/19 for fosfomycin 3 gram packet weekly for urinary tract infection. Review of Resident #4's January MAR revealed: -Fosfomycin 3 gram one packet for a one time order documented as administered on 01/10/19 at 8:00am. -Fosfomycin 3 gram one packet for a weekly order documented as administered on 01/10/19 at 8:00am. -Fosfomycin 3 gram one packet weekly documented as administered on 01/17/19, 01/24/19, 01/25/19, and 01/31/19. Review of Resident #4's February MAR revealed fosfomycin 3 gram one packet weekly documented as administered on 02/01/19,	D 358		

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D 358	Continued From page 41 02/07/19, 02/08/19, 02/14/19, and 02/22/19. Interview with a medication aide (MA) on 03/08/19 at 11:46am revealed: -She was only able to see what medications were to be given on her shift. -She did not know that she had administered Resident #4's fosfomycin on Thursdays weekly and another MA was documenting administering fosfomycin weekly on Fridays between 01/24/19 and 02/15/19. -She was not sure how the mediation cart had extra fosfomycin packets for both nurses to administer twice a week. -She thought they could have administered packets that were left from Resident #4 previously being ordered fosfomycin. -She was not using the fosfomycin 3 gram packets from another resident to administer to Resident #4. Telephone interview with the physician's assistant (PA) on 03/11/19 at 10:18 am revealed: -He ordered Resident #4 fosfomycin 4 gram packet once weekly on 01/23/19 for a urinary tract infection. -He had been told the hospital physician ordered the medication but the facility did not have the prescription. -Resident #4 was to be administered fosfomycin 4 gram packet once weekly, on Thursday or Friday, not both days. -He did not know fosfomycin 4 gram packet was ordered in the MAR for Resident #4 on Thursday and Friday from 01/24/19 to 02/15/19. -He did not know that Resident #4's MAR had documented administration on both Thursday and Friday from 01/24/19 to 02/15/19. -He expected the order to have been clarified and for Resident #4's fosfomycin 4 gram weekly MAR	D 358		

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D 358	Continued From page 42 documentation to be accurate. Interview with Resident #4 on 03/07/19 at 9:15am revealed: -She had a history of urinary tract infections. -She took so many medications she cannot remember what she was given for her urinary tract infection. -She cannot recall how many times a week the fosfomycin packet was administered to her in January or February. -She does not remember if she was ever given fosfomycin twice in one day in January. Interview with a wellness nurse on 03/07/19 at 3:36pm revealed: -The wellness nurses are responsible for transcribing the PA orders into the computer MAR and faxing the order to the pharmacy. -She has never done a record review on any residents, or looked at the MAR documentation. Interview with the resident care director (RCD) on 03/07/19 at 4:06pm revealed: -She expected all resident record reviews to be completed monthly by the wellness nurses during their resident wellness visit. -She expected during the record review the wellness nurses would look at everything including PA orders, MARs, and the medications. -She did not know Resident #4's MAR had fosfomycin 3 gram packet weekly on Thursday and on Friday from 01/23/19 to 02/14/19 documented as administered both days. -There was no house stock of fosfomycin 3 gram packets for the MA's to have administered the medication twice a week from. -She did not know a MA had documented on 01/10/19 at 8:00am administration of fosfomycin 3 gram packet weekly and also at 8:00am	D 358		

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D 358	Continued From page 43 fosfomycin 3 gram packet one time. Interview with the RCD on 03/08/19 at 3:20pm revealed she was told by an MA that they had extra medications on the medication carts from previous resident orders and she believed that is how they administered fosfomycin 3 gram to Resident #4 twice a week. Interview with a wellness nurse on 3/8/19 at 11:55am revealed: -She did not know Resident #4's MAR had an order on 01/10/19 for fosfomycin 3 gram packet once and another order for 01/10/19 both at 8:00am. -She expected that the MA on 01/10/19 would have documented duplicate order on one of the fosfomycin 3 gram packets. -The wellness nurse who entered the 01/23/19 fosfomycin 3 gram packet weekly order should have seen there was already a weekly order for the same medication on Resident #4's MAR. -The MA's should have contacted the wellness nurses to correct the MAR for fosfomycin 3 gram once weekly to be on Thursday or Friday, not both. Interview with the Executive Director on 03/08/19 at 3:28pm revealed: -She did not know that Resident #4's fosfomycin that was ordered for once a week was on the MAR on Thursday and Friday from 01/24/19 to 02/15/19. -She did not know that Resident #4's MAR had documentation of fosfomycin being administered weekly on both Thursday and Friday from 01/24/19 to 02/15/19. -She did not know Resident #4. -She expected that the duplicate weekly fosfomycin order would have been seen during a	D 358		

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D 358	Continued From page 44 record review. -She expected the wellness team to conduct record reviews monthly or bi-monthly. _____ The facility failed to assure medications were administered as ordered which resulted in Coumadin not being held for a resident (#3) with an INR of 4.99 which could lead to uncontrolled bleeding; and an antibiotic ordered weekly for 5 weeks, reordered for weekly, and administered 2 times in one day and 2 times a week for 3 weeks (#4) which could lead to increased chance for adverse side effects like nausea and vomiting, and /or vaginal discharge and itching. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/08/19 for this violation. THE CORRECTION-DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED April 25, 2019.	D 358		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training 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	D 468		

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D 468	Continued From page 45 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 schedules regarding training achievement. (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. (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. (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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff D) who rotated as a Medication Aide (MA) in the Special Care Unit (SCU) had completed 20 hours of training within the first six months. The findings are: Review of Staff D, medication aide's (MA) personnel record revealed: -Staff D was hired on 05/17/18. -There was documentation Staff D had 6.5 hours of special care unit (SCU) training completed 05/30/18. -There was no documentation Staff D had an	D 468		

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D 468	Continued From page 46	D 468		

additional 20 hours of SCU training during her first six months.
-There was documentation Staff D had an additional 6 hours training completed on 02/21/19.
-There was no other documentation of additional SCU training for Staff D.

Interview with Staff D on 03/11/19 at 10:42am revealed:
-She started working in the first week of June 2018.
-She had SCU training during orientation; she did not recall how many credit hours she received but it had been an all-day training.
-She also had computer training on dementia; she did not recall how long the computer training was.
-She had dementia training at a staff meeting last month in the SCU.
-She did not recall if anyone told her she needed 20 hours of SCU training within the first six months in addition to the initial 6 hours of training.
-She worked in the SCU as a MA about once per week; she worked this past weekend (03/09/19-03/10/19).

Interview with the Business Office Manager (BOM) on 03/11/19 at 1:12pm revealed:
-She was responsible for making sure the staff who worked in the SCU had training.
-The SCU Coordinator was responsible for actual dementia training.
-She did not know staff who worked in the SCU needed an additional 20 hours training within the first six months of hire.

Interview with the Executive Director (ED) on 03/11/19 at 1:40pm revealed:
-The BOM was responsible for personnel

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D 468	Continued From page 47 records. -She did not know Staff D did not have the required SCU training. -She expected all training to be completed within the required time frame.	D 468		
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 assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (#2, #3, and #4) related medications not discontinued or changed from scheduled to as needed after a hospital discharge (#2), Coumadin not being held for a resident (#3) with an international normalized ratio (INR) of 4.99, and	D912		

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D912	Continued From page 48 an antibiotic ordered weekly for 5 weeks, reordered for weekly, and administered 2 times in one day and 2 times a week for 3 weeks (#4). [Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	D912		
D917	G.S. 131D-21(7) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 7. To receive a reasonable response to his or her requests from the facility administrator and staff. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to respond to resident (#4, and #9) call bells requesting assistance in a timely manner. The findings are: 1. Review of Resident #4's current FL2 dated 04/26/18 revealed: -Diagnoses included cerebral infarction, dysphagia, hypertension, hyperlipidemia, hemiplegia, GERD, Parkinson's, muscle weakness, dementia, and hemiplegia. -Resident #4 was total care. Interview with Resident #4 on 03/06/19 between 9:56am and 11:20am revealed: -She had two strokes and had weakness on one side, she was now in a wheelchair. -She was unable to move one side of her body and at times struggled to press the call bell on her right forearm. -The facility staff provided assistance for her bathing, toileting, and dressing and assisted her with feeding. -Staff checked on her about every 3 hours and	D917		

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D917	Continued From page 49	D917		

when she used her call bell it did not seem to help staff come faster.
-Staff provided care with two staff at a time using a hoyer lift.
-Some staff seem annoyed when she needed assistance.

Observation of Resident #4 in her room on 03/06/19 between 10:10am and 11:20am revealed:
-She needed assistance to use the bathroom and pressed her call bell, worn on her right forearm, at 10:10am.
-She had a sign over her bed that said "only staff was allowed to transfer and toilet Resident #4, if you needed assistance press the call bell".
-A staff member peeked her head in carrying a trash bag and said "hi" then walked out at 10:15am.
-Resident #4 did not see or hear the staff member peek her head in the room since she was in a wheelchair with her back to the door.
-Resident pressed call bell a second time at 10:30am and by 11:20am there was no response from staff.
-Staff responded to call bell at 11:30 am and assisted the resident with toileting.

Interview with a medication aide (MA) on 03/06/19 at 11:22am revealed:
-The MA's phones did not receive the call bell alerts.
-She did not know why Resident #4 pressed her call bell and did not receive assistance.
-Resident #4 was a two person assist when providing her care.
-The personal care aides (PCA) had all the call bells directed to their phones.
-She tried calling the PCA assigned to Resident #4's care and she did not answer.

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D917	Continued From page 50 -The PCA assigned to the hall usually took lunch between 11:00am and 11:30am, another PCA covered her hall during her lunch break. Interview with a PCA on 03/06/19 at 11:40am revealed: -When a resident pressed their call bell for assistance it went to the PCA phones directly what room was calling for assistance. -Staff had to walk into a resident room to cancel the call bell. -Staff were to check on residents frequently, about every hour throughout their shift and offer assistance. -Sometimes she had felt there were not enough PCA's on a shift to take care of the resident call bells and personal care needs. -There had been a rare shifts when a PCA had up to 18 residents to provide their personal care needs. -When a PCA had over their normal 6-12 residents it was harder to provide good care and respond to call bells quickly. -All call bells from the time a resident pushed to the response time of staff could be seen by the assisted living coordinator. -She has had a difficult time responding before when multiple residents needed assistance at the same time. -It was difficult when a resident that was a two person assist needed assistance because she often had to wait for another PCA to be able to assist. -She did not know why Resident #4's call bell was pressed multiple times and no staff assisted. Interview with a PCA on 03/07/19 at 3:30pm revealed: -She was hired in the past few weeks and was trained to check on all residents every 30 minutes	D917		

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D917	Continued From page 51	D917		

throughout her shift.
-She had 12 residents she was providing care for on her current shift.
-Her phone received a ring and she could then see which resident pressed their call bell from her phone.
-She could cancel room call alarms from her phone without going into the room but the resident would have to push the call light again if they still needed assistance.
-There were several residents in the building that required 2 PCA's to assist the resident and it took longer to provide assistance to these residents because the other PCA had to finish providing care to their resident.
-All PCA's had been trained to use resident hoyer lifts.

Interview with assisted living coordinator on 03/07/19 at 3:50pm revealed:
-She expected resident call bells to be responded to in 5-10 minutes.
-When she was told about residents having to wait a longer period of time she looked at the call bell logs.
-Once a family member told her that a resident pushed the call bell and there was no response, because the call bell needed to be replaced.
-She did not have a log of call bells that had been replaced.
-She expected every resident to be checked every 1-2 hours and offered care.
-PCA's were assigned 8-10 residents to care for per shift, never more.
-The PCA's can clear the call and respond to the resident and not turn off alert in the system.
-When the PCA does not turn off the alert from the call bell it recorded very long wait times in the call log system.
-She did not know Resident #4's call bell was

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D917	Continued From page 52 pressed multiple times and no staff assisted. Interview with a wellness nurse on 03/07/19 at 3:36pm revealed she expected call bells to be answered within 10 minutes. Interview with the resident care director (RCD) on 03/07/19 at 4:06pm revealed she expected the PCA's to respond call bells ideally in 3-5 minutes. Interview with the maintenance director on 03/08/19 at 11:36am revealed: -He was not aware of any call bells that were not working. -He conducted monthly checks of all resident call bells checking the bed, bathroom, and resident receivers. -During monthly call bell checks he looked at computer reports to check all the alerts were working and cancel the system requests. -The system monitored the battery level and he received an alert when the battery on a call bell needed to be replaced. Interview with the Executive Director (ED) on 03/11/19 at 3:28pm revealed: -There was no official policy on call bell response time for staff. -She expected staff to respond to resident call bells within 7-10 minutes. -She had requested to see the call bell response time log on 03/07/19 and was "flabbergasted" by some of the lengthy response times she saw. -She did not know Resident #4 on 03/06/19 pressed her call bell more than once in a 1 hour and 10 minute time period and one staff member only peeked in to say "hi" and no one else offered help to the resident. 2. Review of Resident #9's current FL2 dated	D917		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034026	A. BUILDING: _____ B. WING _____	03/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF WINSTON SALEM	2601 REYNOLDA ROAD WINSTON SALEM, NC 27106

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D917	Continued From page 53 12/10/18 revealed diagnoses included asthma, hypertension, cardiomegaly, diabetes, congestive heart failure, hyperlipidemia, and acute respiratory failure. Interview with Resident #9 on 03/07/19 at 3:18pm revealed: -She wore continuous oxygen 2L/per nasal cannula. -She had in the past few months pressed the call bell for assistance when she was short of breath. -Sometimes it had taken an hour or two for staff to respond to her call bell and offer her assistance. -She was anxious when it took staff longer to respond to her call bell. -Some staff seemed like they were being inconvenienced when they responded to her request for assistance. -She had in the past few days pressed the call bell for assistance going to the bathroom and it took staff so long she soiled herself before they came to assist her. Observation of Resident #9 in her room on 03/07/19 at 3:18pm revealed she was had to stop talking twice to breathe deeply before she could continue talking. Interview with a medication aide (MA) on 03/06/19 at 11:22am revealed: -The MA's phones did not receive the call bell alerts. -The personal care aides (PCA) had all the call bells directed to their phones. Interview with a personal care aide (PCA) on 03/06/19 at 11:40am revealed: -When a resident pressed their call bell for assistance it went to the PCA phones directly	D917		

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D917	Continued From page 54	D917		

what room was calling for assistance.
-Staff had to walk into a resident room to cancel the call bell.
-Staff were to check on residents frequently, about every hour throughout their shift and offer assistance.
-Sometimes she had felt there were not enough PCA's on a shift to take care of the resident call bells and personal care needs.
-There had been a rare shifts when a PCA had up to 18 residents to provide their personal care needs.
-When a PCA had over their normal 6-12 residents it was harder to provide good care and respond to call bells quickly.
-All call bells from the time a resident pushed to the response time of staff could be seen by the assisted living coordinator.
-She has had trouble responding before when multiple residents need assistance at the same time.
-She has had a difficult time responding before when multiple residents needed assistance at the same time.

Interview with a MA on 03/07/19 at 3:27pm revealed:
-She did not know how long it took PCA's to respond to call bells.
-Resident #9 was a one person assist for her care needs.
-Resident #9 at times was incontinent.
-She did not know if Resident #9 had pressed her call bell before when she was short of breath.
-She did not know why Resident #9 was on oxygen.

Interview with a PCA on 03/07/19 at 3:30pm revealed:
-She was hired in the past few weeks and was

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D917	Continued From page 55	D917		

trained to check on all residents every 30 minutes throughout her shift.
-She had 12 residents she was providing care for on her current shift.
-Her phone received a ring and she could then see which resident pressed their call bell from her phone.
-She could cancel room call alarms from her phone without going into the room but the resident would have to push the call light again if they still needed assistance.

Interview with assisted living coordinator on 03/07/19 at 3:50pm revealed:
-She expected resident call bells to be responded to in 5-10 minutes.
-When she was told about residents having to wait a longer period of time she looked at the call bell logs.
-Once a family member told her that the resident pushed the call bell and there was no response, because the call bell needed to be replaced.
-She did not have a log of call bells that had been replaced.
-She expected every resident to be checked every 1-2 hours and offered care.
-PCA's were assigned 8-10 residents to care for per shift, never more.
-The PCA's can clear the call and respond to the resident and not turn off alert in the system.
-When the PCA does not turn off the alert from the call bell it recorded very long wait times in the call log system.
-She had not heard of Resident #9 pushing her call bell and it taking staff over an hour to respond when the she was short of breath.

Interview with a wellness nurse on 03/07/19 at 3:36pm revealed she expected call bells to be answered within 10 minutes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D917	Continued From page 56 Interview with the resident care director (RCD) on 03/07/19 at 4:06pm revealed she expected the PCA's to respond call bells ideally in 3-5 minutes. Interview with the Executive Director (ED) on 03/11/19 at 3:28pm revealed: -There was no official policy on call bell response time for staff. -She expected staff to respond to resident call bells within 7-10 minutes. -She had requested to see the call bell response time log on 03/07/19 and was "flabbergasted" by some of the lengthy response times she saw. -She did not know Resident #9 had pressed her call bell previously when she was short of breath and it took staff over an hour to respond.	D917		

Sunrise Senior Living
Plan of Correction

Name of Community: Brighton Gardens Of Winston Salem
Address: 2601 Reynolda Dr Winston-Salem, NC 27106
License number: HAL-034-026
Inspection date(s): 03/06/19-03/08/19 and 03/11/19
Name and Title of Sunrise Representative Signing the Plan of Correction:
Nilsa Aquino Rivera , Executive Director
Signature of Sunrise Representative: Nilsa A. Rivera.
Date of Submission: 04/22/19

Regulation	Target Date by Which Correction will be completed	Plan of Correction
10NCAC 13F .0406(a) Test For Tuberculosis	04/04/19	**A. With respect to the specific resident/situation cited:** In respect to the three team members identified during the survey (staff C, D, and F), They received a two-step Tuberculosis Test. The three team members were found to have negative results for TB. Results of the TB tests were placed in the Health Binder by the Business Office Coordinator.
	3/29/19 04/19/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Business Office Coordinator/Designee completed audit of team member files on 03/29/19 to confirm the completion of 2 step TB screenings. Issues identified were addressed and resolved. Team member files that did not reflect documentation of a 2 Step TB test: the team members received a 2 step TB screening test.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		2 Step TB screenings were resolved on 04/19/19.
	4/16/19 4/10/19 4/10/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** The BOC or designee will audit new team member files weekly for 1 month and then monthly for 2 months to confirm 2 Step TB screening tests were completed. The results of the audits will be reviewed at Quality Assurance and Performance Improvement (QAPI) Meetings monthly for 3 months. During and at the conclusion of the 3 months the QAPI Committee will re-evaluate and initiate any necessary action or extend the review period.
	3/29/19	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.
10 NCAC 13F .0407 (a)(5) Other Staff Qualifications	03/08/19	**A. With respect to the specific resident/situation cited:** In respect to the two team members identified (staff D and F), the Business Office Coordinator completed Health Care Personnel Registry checks on the day of survey 3/08/2019. Both Team Members Health Care Personnel Registry check had no findings and the confirmation was placed in team member files by the BOC.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	03/29/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Business Office Coordinator/Designee conducted audit of team member files on 3/29/2019. Issues identified were addressed and resolved - Health Care Personnel Registry checks were completed and there were no findings for the team members who were checked in the Registry.
	4/16/19 4/10/19 4/10/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** The BOC or ED or designee will audit new team member files weekly for 1 month and then monthly for 2 months to confirm Health Care Personnel Registry checks were completed. The results of the audits will be reviewed at Quality Assurance and Performance Improvement (QAPI) Meetings monthly for 3 months. During and at the conclusion of the 3 months the QAPI Committee will re-evaluate and initiate any necessary action or extend the review period.
	3/8/19	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.
10A NCAC 13F .0904(a)(1) Nutrition and food Service	03/8/19	**A. With respect to the specific resident/situation cited:** On 03/07/19 and 03/08/19 a thorough cleaning of the Kitchen and Dining areas were completed by the kitchen team members, with direction and supervision by the Executive Director and the Regional Director of Dining Services.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	4/4/19 4/5/19 and 4/17/19	The cleaning and sanitation process included the: ice machine, steam table, stove, grill, fryer, floors, walls and metal wire shelving. Professional Deep Cleaning of the kitchen walls and floors was completed by a vendor on 04/04/2019 and additional cleaning completed 4/16/19 The ED and DSC inspected the kitchen and confirmed that the vendor effectively accomplished the assigned projects.
	3//10/19 4/8/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** Following the cleaning and sanitation on 03/07/19 and 03/08/19, the Executive Director and the Regional Director of Dining Services conducted observational rounds of the kitchen on 03/10/19 to confirm that the tasks were effectively accomplished. The Executive Director conducted observational rounds of the kitchen weekly for 4 weeks following the 03/08/19 cleaning to confirm the cleanliness and sanitation status of the kitchen. Matters identified were addressed and resolved and on the spot refresher training initiated as needed.
	4/15/19 3/10/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** The Dining Services Coordinator (DSC) has implemented the use of daily/weekly/monthly cleaning task schedules. The DSC and/or ED will observe and check the performance of the Dining Staff weekly for 3 months to confirm appropriate completion of the tasks. Issues identified will be addressed and resolved and refresher training initiated. Dining department staff received refresher training conducted by the Dining Services Coordinator on 03/10/19 on proper

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		cleaning, sanitizing, cleaning protocols, cleaning schedules, their specific assignments, and use of hairnets. 3/28/19 During the Whole House Team Member Town Hall Meeting, the ED conducted training regarding the use of hairnets and the protocols for entering the kitchen. 4/10/19 Additional refresher training was conducted on 04/10/19 by the Dining Services Coordinator with the Dining Staff regarding the use of hairnets and Sanitation Procedures. New dining team members will be trained on the proper cleaning methods and use of cleaning tasks schedules by the DSC or designee during the orientation and on-boarding process.
	3/8/19	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.
10A NCAC 13f.1002 Medication Orders – Standard Deficiency	03/11/19	**A. With respect to the specific resident/situation cited:** Resident #5 No longer resides at community Resident #4 did not experience a negative outcome as a result of antibiotic medication administration. Family and PA were notified on day of survey (03/11/19) regarding the antibiotic doses that were administered. No new orders were received from the PA. PA visited the community on 03/27/19, made a clinical visit to resident # 4, and confirmed continuation of antibiotic order. .

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:
	3/8/19	The Resident Care Director (RCD) and Wellness nurse conducted an audit on 03/08/19 to confirm orders were entered into eMAR correctly and that there was no duplication of physician orders. Issues identified were addressed and resolved and physicians contacted as needed.
	3/8/19	The Resident Care Director and Wellness nurse conducted an audit on 03/08/19 to confirm FL2s were transcribed correctly and that there were no discrepancies with or duplications of orders. Matters identified were addressed and resolved and physicians contacted as needed.
	04/10/19	RCD and wellness nurses completed SCC/Point Click Care training on 04/10/19 to enhance their skills with the EMAR program, including entering new orders or changes to existing orders. The SCC training was conducted online through a Sunrise Senior Living webinar.
		C. With respect to what systemic measures have been put into place to address the stated concern:
	03/15/19	The process has been adjusted to include the following: New FL2s are transcribed, reconciled with current orders, and doubled checked by two nurses prior to contacting Physicians for review and signature. Nurses will continue to do Resident Wellness visits including a med review to confirm orders are transcribed correctly on eMAR. If a discrepancy is identified the Nurses will notify the Primary Care Physician and the Resident Care Director immediately for clarification order.
	3/15/19	Order entry refresher training was conducted on 03/15/19 for the Wellness Nurse Team by RCD. The training also included the process for conducting a double check of order entry by two nurses or a nurse and a med tech.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	3/15/19 4/10/19 4/10/19	Resident Care Director will audit monthly Wellness visits and audit order entries for the next three months, if discrepancies are noted, the Primary Care Physician will be notified for a clarification order, and the eMAR will be updated per physician order. The RCD or designee will report findings of the audits including discussions regarding root cause analysis and process improvement plans and interventions to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after the 3 months, the QAPI Team will re-evaluate and initiate necessary action or extend the review period as needed based on issues identified or trends observed.
	3/8/19	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.
10A NCAC 13F.1004 Medication Administration TYPE B	03/08/19 3/13/19	**A. With respect to the specific resident/situation cited:** Resident #3 did not experience a negative outcome as a result of Coumadin medication administration. Dialysis Center nurse and PA notified on 03/08/19 by the RCD. Orders were clarified with the PA and entered into eMAR. PA visited the community on 03/13/19, made a clinical visit to resident # 3, med review completed and issued new orders.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		PA spoke with Miller Street Dialysis and informed dialysis center that PA would manage Coumadin orders going forward. On 03/28/19 the PA discontinued Coumadin orders and changed to PO med that does not require labs and frequent med changes. Resident # 2 No longer resides at community
	3/11/19	Resident #4 did not experience a negative outcome as a result of antibiotic medication administration. Family and PA were notified on day of survey (03/11/19) regarding the antibiotic doses that were administered. No new orders were received from the PA. PA visited the community on 03/27/19, made a clinical visit to resident # 4, and confirmed continuation of antibiotic order.
	3/8/19 04/10/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Resident Care Director and Wellness nurse conducted an audit on 03/08/19 to confirm Coumadin orders were entered into eMAR per physician orders. Issues identified were addressed and resolved and physicians contacted as needed. RCD and wellness nurses completed SCC/Point Click Care training on 04/10/19 to enhance their skills with the EMAR program, including entering new orders or changes to existing orders. The SCC training was conducted online through Sunrise Senior Living webinar.
	4/1/2019	**C. With respect to what systemic measures have been put into place to address the stated concern:** Nurses will continue to do Resident Wellness visits including a medication review to confirm orders are transcribed correctly on eMAR. If a discrepancy is identified, the Nurses will notify the Primary Care Physician and the Resident Care Director immediately for a clarification order.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	3/15/19 3/15/19 4/10/2019 4/10/2019	Order entry refresher training was conducted on 03/15/19 for the Wellness Nurse Team by RCD. The training also included the process for conducting a double check of order entry by two nurses or a nurse and a med tech. Resident Care Director will audit monthly Wellness visits and audit order entries for the next three months, if discrepancies are noted, the Primary Care Physician will be notified for a clarification order, and the eMAR will be updated per physician order. The RCD or designee will report findings of the audits including discussions regarding root cause analysis and process improvement plans and interventions to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after the 3 months, the QAPI Team will re-evaluate and initiate necessary action or extend the review period as needed based on issues identified or trends observed.
	3/8/19	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.
10 NCAC 13F - 1309 Special Unit Staff Orientation and Training	04/08/19	**A. With respect to the specific resident/situation cited:** In respect to the team member (Staff D) identified during the survey, the Team Member completed SCU training on 04/08/2019 and the completion was documented and filed in the training binder by the BOC.
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	3/23/19 04/23/19	The Business Office Coordinator conducted an audit of team member files on 03/23/19 to confirm SCU training was completed. Team member files that did not reflect the completion of SCU training received SCU training conducted by the Reminiscence Coordinator/designee and Moffitt sponsored on-line training by 04/23/19.
	4/17/19 4/10/19 4/10/19 4/15/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** The BOC and/or ED will audit new team member files for 3 months to confirm SCU training has been completed. The results of the audits will be reviewed at Quality Assurance and Performance Improvement (QAPI) Meetings monthly for 3 months. During and at the conclusion of the 3 months the QAPI Committee will re-evaluate and initiate any necessary action or extend the review period Executive Director will audit new hire files upon 6-month anniversary for 3 month to review completion of 20 SCU Training.
	3/2/319	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
G.S. 131-D-21 (2) Declaration of Residents' Rights	03/08/19 3/13/19 03/11/19	**A. With respect to the specific residents/situation cited:** Team Members received refresher training on Resident Rights by the Executive Director/designee dates and were given a copy of the Declaration of Residents' Rights for review and to provide a signature of acceptance. Resident #3 did not experience a negative outcome as a result of Coumadin medication administration. Dialysis Center nurse and PA notified on 03/08/19 by the RCD. Orders were clarified with the PA and entered into eMAR. PA visited the community on 03/13/19, made a clinical visit to resident # 3, med review completed and issued new orders. PA spoke with Miller Street Dialysis and informed dialysis center that PA would manage Coumadin orders going forward. On 03/28/19 the PA discontinued Coumadin orders and changed to PO med that does not require labs and frequent med changes. Resident # 2 No longer resides at community Resident #4 did not experience a negative outcome as a result of antibiotic medication administration. Family and PA were notified on day of survey (03/11/19) regarding the antibiotic doses that were administered. No new orders were received from the PA. PA visited the community on 03/27/19, made a clinical visit to resident # 4, and confirmed continuation of antibiotic order.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	04/10/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Resident Care Director and Wellness nurse conducted an audit on 03/08/19 to confirm Coumadin orders were entered into eMAR per physician orders. Issues identified were addressed and resolved and physicians contacted as needed. RCD and wellness nurses completed SCC/Point Click Care training on 04/10/19 to enhance their skills with the EMAR program, including entering new orders or changes to existing orders. The SCC training was conducted online through Sunrise Senior Living webinar.
	03/15/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** Nurses will continue to do Resident Wellness visits including a medication review to confirm orders are transcribed correctly on eMAR. If a discrepancy is identified, the Nurses will notify the Primary Care Physician and the Resident Care Director immediately for a clarification order Order entry refresher training was conducted on 03/15/19 for the Wellness Nurse Team by RCD. The training also included the process for conducting a double check of order entry by two nurses or a nurse and a med tech. Resident Care Director will audit monthly Wellness visits and audit order entries for the next three months, if discrepancies are noted, the Primary Care Physician will be notified for a clarification order, and the eMAR will be updated per physician order. The RCD or designee will report findings of the audits including discussions regarding root cause analysis and process improvement plans and interventions to the Quality Assurance Performance Improvement Committee monthly for 3 months.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		During and after the 3 months, the QAPI Team will re-evaluate and initiate necessary action or extend the review period as needed based on issues identified or trends observed
	3/29/19	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.
G.S.131-D-21 (7) Declaration of Residents' Rights	4/10 - 4/24/19	**A. With respect to the specific residents/situation cited:** Team Members received refresher training regarding the process for responding on a timely basis to call system activation and resetting the system upon entering a resident apt. The refresher training was conducted by the Department Coordinators (DC) between 4/10 -4/24/19. The ED met with Residents #4 and #9 on 04/09/19 to confirm expectations for call system response and ED or designee will touch base with these 2 residents weekly for 1 month.
	04/16/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The ED and/or designee interviewed residents to confirm timely call system response and conducted unannounced call system activations on 04/02/19 and 04/16/19 to confirm timely response. Matters identified were addressed and resolved and on the spot in the moment refresher training initiated as needed. The AVC or designee met with the Residents' Council on 04/09/19 date to discuss and confirm call system response and elicit feedback.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	3/18/19	**C. With respect to what systemic measures have been put into place to address the stated concern:** The ED, Care Coordinators (ALC, RC) are conducting weekly unannounced call system activations and call system response observations for 3 months to confirm that residents receive a timely response. The AVC or designee will meet with the Residents' Council monthly for 3 months to confirm call system response and elicit feedback. The results of the activations, audits, and resident council feedback will be reviewed at Quality Assurance and Performance Improvement (QAPI) Meetings monthly for 3 months. During and at the conclusion of the 3 months the QAPI Committee will re-evaluate and initiate any necessary action or extend the review period.
	3/29/19	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.