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BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 07/09/19-07/11/19.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure referral and follow-up for the routine and acute health care needs for 1 of 5 sampled residents (#3) as related to failure to notify hospice services of new open areas in the skin on the buttocks. The findings are: Review of Resident #3's current FL-2 dated 05/10/19 revealed: -Diagnoses included dementia with Lewy bodies, hypertension (HTN), magnesium deficiency, hyperlipidemia, Parkinson's disease, dysphagia, xerosis cutis, hypothyroidism, and multiple system degeneration of the nervous system. -The resident's level of orientation was not documented. -The resident was non-ambulatory, and incontinent of bladder and bowel.	{D 273}		

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{D 273}	Continued From page 1 Review of Resident #3's Personal Service Plan dated 05/10/19 revealed: -There was documentation the resident was oriented to person, place, and time and could communicate needs and preferences. -There was documentation the resident was incontinent of bowel and bladder and required assistance with toileting. - Assist with pulling pants up and down, assist with changing protective undergarments. - Be alert to redness, irritation, and breakdown when providing bathroom assistance. Telephone interview with Resident #3's power of attorney (POA) on 07/10/19 at 9:22am revealed: -Resident #3 was unable to complete any of his activities of daily living (ADLs) independently and required staff assistance for all ADLs. -Beginning in November 2018, Resident #3 was diagnosed with an autoimmune disease which caused him to have blisters on his skin in areas to include his hands, feet, shoulders, chest, and arms. -The areas on the skin with blisters required daily dressing changes. -Resident #3 was being treated by dermatology for the autoimmune disease. -Resident #3 was on hospice. -Hospice completed Resident #3's dressing changes Monday-Friday. -Facility staff completed Resident #3's dressing changes on Saturday and Sunday. -The POA had last visited the resident on Sunday (07/07/19) and the resident had no complaints. -The POA did not know if Resident #3 had any current dressings. Interview with Resident #3 on 07/10/19 at 9:04am revealed: -He needed assistance from staff with bathing,	{D 273}		

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shaving, and incontinence care.
-He did not currently have any dressings.
-He had blisters for about 2 months to his hands, shoulders, and feet. He was "about well now"; however; the blisters were itchy and caused him pain.
-He previously received shots for the blisters given to him by his primary care provider (PCP).

Observations on 07/10/19 at 9:47am revealed:
-The hospice Registered Nurse (RN) performed a skin assessment in Resident #3's room while he was seated in his recliner.
-The hospice RN performed a skin assessment of Resident's #3's left shoulder which revealed two scabbed areas; the skin was intact without any open areas.
-The hospice RN performed a skin assessment of Resident's #3's chest which revealed multiple scabbed areas; the skin was intact without any open areas.
-The hospice RN performed a skin assessment of Resident's #3's left foot which was negative for blisters; the skin was intact without any open areas.
-Two resident aides (RAs) arrived in Resident's #3's room to assist with transferring Resident #3 to a standing position with his walker.
-The hospice RN performed a skin assessment of Resident's #3's bilateral groin areas; the skin was intact without any open areas.
-Resident #3 ask to the hospice RN to check his buttocks.
-Resident #3's adult protective undergarment was removed by the RAs and hospice RN in order for the hospice RN to visualize his buttocks.
-There were three open areas on Resident #3's buttocks which were measured by the hospice RN.
-The hospice RN stated, "These open areas are

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{D 273}	Continued From page 3 new, they were not seen until now." -There was an open area on the left buttocks that was round measuring approximately the size of a pencil eraser. -There was a second linear shaped open area on the left buttocks that measured approximately 2 cm x 1 cm with unknown depth. -There was a third open area on the left buttocks below the linear shaped open area that measured approximately 1 cm x 1 cm with unknown depth. -The two RAs said the open areas on Resident #3's buttocks were new and they had no knowledge of the open areas prior to that time (07/10/19 at 9:47am). Interview with the Executive Director (ED) and the Health and Wellness Director (HWD) on 07/10/19 on 10:25am revealed: -There was no specific frequency for toileting rounds; the general rule was for staff to provide toileting assistance to incontinent residents every 2-3 hours. -Residents with severe skin breakdown would be on a toileting schedule, if ordered by their PCP. -Resident #3 did not have an order for a toileting schedule. -Toileting rounds were not documented. -The "floor staff" which included the RAs and medication aides (MAs) knew and were reminded by clinical staff (nurses) that if a resident was on hospice, the facility staff was still responsible for assuring the resident's ADL's and personal care needs were met and changes in condition were reported as needed. -If there were any issues related to skin breakdown, the HWD or the Clinical Specialist (CS) should be notified along with the supervisor or the MA.	{D 273}		

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{D 273}	Continued From page 4 Interview with Resident #3 on 07/10/19 on 10:51am revealed: -His buttocks started hurting about a month ago but he did not tell anyone. -The pain to his buttocks had gotten worse in the last two to three days. -His adult protective undergarment was changed four to five times a day by staff when they came to check on him. -Staff had changed his protective undergarment last night (07/09/19) and this morning (07/10/19). -Within the "last day or two", staff saw a "sore" on his bottom when they were changing him. -He did not know who the staff was that saw the sore. -The staff put a "salve and a powder" on the sore. -Last night, (07/09/19), staff "rubbed something" on the sore on his buttocks that made it feel better. Interview with the hospice RN on 07/10/19 on 11:00am revealed: -The hospice aide came to the facility five days a week to complete Resident #3's personal care needs which included changing bed linens, bathing, dressing, toileting, or any kind of ADL. -The hospice aide would communicate any personal care issues or changes in condition to the hospice RN. -The last hospice visit by an RN for Resident #3 was Friday of last week (07/05/19). -A "head-to-toe assessment" was completed by hospice for Resident #3 on 07/05/19. -If the skin breakdown observed on Resident #3's buttocks today (07/10/19) had been observed on 07/05/19, it would have been documented by hospice on 07/05/19. -She had notified Resident #3's hospice physician of the new open areas on the buttocks today (07/10/19) and new wound care orders were	{D 273}		

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received.
-She acknowledged she was first made aware of the open areas on the buttocks when Resident #3 requested she observe his buttocks earlier that day (07/10/19).
-The facility staff had not notified her or the hospice provider of the new open areas to Resident #3's buttocks.
-Staff should have notified hospice when the open areas were first observed so she could have contacted the hospice physician for wound care orders.
-The MAs on duty were expected to notify hospice by telephone for any change in Resident #3's condition to include a change in his skin condition.
-The hospice agency had a 24-hour service available for any changes to be reported.
-Resident #3 had never complained to her of pain to his buttocks until today (07/10/19).

Interview with a medication aide/resident aide (MA/RA) on 07/10/19 on 11:19am revealed:
-Resident #3 required total care.
-Resident #3 was incontinent and needed help from staff with all ADLs.
-Resident #3 was able to voice his concerns.
-Resident #3 was able to stand for adult protective undergarment changes which were completed three to four times per shift.
-The RA last changed Resident #3's adult protective undergarment prior to lunch at 10:30 am on 07/10/19.
-The RAs would typically automatically check on residents every two hours.
-Resident #3 currently did not have any dressings.
-Skin assessments were completed on admission and every 30 days by the MA or RA.
-The RA would notify the MA of any changes to

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the skin and then the MA would share findings with the HWD. The HWD would then notify the PCP or hospice.
-The RA would report any change in conditions to the medication aide (MA). The MA would evaluate, address, and document the change in condition. The MA would then notify the hospice RN which was the facility's protocol when reporting a change in condition for a resident.
-Resident #3 had not had any new complaints of pain on 07/10/19.
-Rounding reports were completed at the change of shift.
-She acknowledged she did not receive any info about the open areas in shift report on 07/10/19.

Interview with a second MA/RA on 07/10/19 between 11:35am-11:55am revealed:
-RA duties included completing rounds, dressing residents, washing resident's back side, removing trash, making beds, and bringing residents to lunch/dinner.
- At the change of shift, the staff walked the halls together and completed verbal report for each resident; changes were supposed to be discussed during report.
-There were no problems or changes for Resident #3 reported to her by the third shift staff at change of shift report on 07/10/19.
-The MA would have documented changes in the skin, if problems were reported.
-Resident #3 was a total care.
-Incontinence care was completed before and after breakfast, and every 2 hours.
-On Monday, 07/08/19, she observed a small amount of blood in Resident #3's adult protective undergarment but there was no skin breakdown; she notified the MA about the blood on 07/08/19.
-Skin assessments would be completed when a supervisor asked. The RAs document on skin

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assessment sheet and any skin changes would be reported to the supervisor. Then any changes to the resident's skin would be reported to the RN. On the weekends, the supervisor/MA would be notified.

Telephone interview with a RA on 07/10/19 at 03:17pm revealed:
-Resident #3 was a total care; he couldn't do for himself.
-She was the RA on duty assigned to Resident #3's hallway on Monday (07/08/19) and Tuesday (07/09/19) nights.
-When changing Resident #3 on Monday and Tuesday nights (07/08/19 and 07/09/19), she observed open areas and bleeding on the resident's buttocks.
-She applied cream to the areas when she changed Resident #3's adult protective undergarment on 07/08/19 and 07/09/19. The cream she used was in a tube kept in the resident's room.
-Resident #3 was changed every two hours.
-The facility procedure for a change in a resident's condition was for the RA to report the change to the MA; and then the MA notified the PCP.
-If she saw a new area of skin breakdown while changing a resident that had not been there before, she would fill out a skin assessment sheet and report it to the supervisor.
-On weekdays, the supervisor was the nurse; on weekends, the supervisor was the MA.
-There were no issues or changes reported during the night shifts on 07/08/19 and 07/09/19.
-Resident #3's wound on his buttocks had been there "a while"; it was "nothing new."
-Resident #3 had complaints of hurting in the buttocks before Monday and Tuesday (07/08/19 and 07/09/19); Resident #3 had no complaints of

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pain on Monday or Tuesday nights.
-She applied cream to Resident #3 buttocks every time he was changed.
-She did not report the open areas or bleeding on Resident #3's buttocks to anyone on 07/08/19 or 07/09/19 because it was "nothing new."

Interview with a MA on 07/11/19 at 10:30am revealed:
-Resident #3 was total care and required assistance from staff with all ADLs.
-She worked as a MA on the first shift on Sunday, 07/07/19.
-Resident #3 received incontinence care three to four times per shift. After breakfast, after lunch, then again at 2:00pm.
-The resident was stood up with a gait belt and a "quick check" would be completed.
-A "quick check" was completed with gloves; the MA would push on the adult protective undergarment with two fingers to check if the resident was incontinent. With the "quick check" or if an incontinent episode occurred the MA acknowledged the resident's entire buttocks could be seen.
-She had observed blisters on Resident #3's buttocks on 07/07/19 but did not report anything.
-Resident #3's blisters on his buttocks were "nothing new."
-Powder was applied to Resident #3's buttocks on 07/07/19.
-The facility protocol was as follows: if there were changes to the resident's skin, a skin assessment and a progress note would have been completed by the MA. Then the hospice RN would be notified of any skin changes by the MA.
-At the change of shift, the staff walked the halls together and completed verbal report for each resident; changes were supposed to be discussed during report.

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{D 273}	Continued From page 9 Interview with a second MA on 07/11/19 at 10:07am revealed: -A few weeks ago, the MA received notification that Resident #3 had breakdown to his groin area. -She had not been notified by any staff last week or this week of any open areas to Resident #3's buttocks. -The facility procedure for a change in the resident's condition was for the RA to report the change to the MA; the MA would notify hospice. Interview the HWD and the CS on 07/10/19 at 04:34pm revealed: -Resident #3 was a total care and required staff assistance with all ADLs. -Resident #3 was on hospice. -If there were any skin abnormalities, hospice would be notified by the MA or the HWD and document the findings. -The hospice aide came to the facility to complete Resident #3's personal care needs 5 days a week. -The hospice RN would visit weekly unless he had dressings. When the resident had dressings, the hospice RN came daily for dressing changes (Monday through Friday) and facility staff would complete the dressing changes on the weekends. -Skin assessments were done quarterly by floor staff (MA or RA), then reviewed or signed off by a nurse. -The MA or clinical staff would notify hospice of any changes. -Resident #3's Braden score was 15 per the skin assessment dated 06/26/19. (The Braden Scale is a tool used to predict the resident's risk in the development of a skin breakdown). There were no open areas documented on the last skin assessment dated 06/26/19.	{D 273}		

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{D 273}	Continued From page 10 -All staff had been trained on hire to report changes in status and condition. -Changes in status/condition were discussed at the daily stand up meeting held each morning. -At the change of shift, the staff walked the halls together and completed verbal report for each resident; changes were supposed to be discussed during change of shift report. -The HWD and the CS weren't aware of the open areas on Resident #3's buttocks until the hospice RN notified them on 07/10/19. -The RAs did not notify the MA/supervisor, the HWD, and/or the CS so hospice could have been notified. -Hospice should have been notified at the time the open areas on Resident #3's buttocks were found. Interview the ED on 07/10/19 at 04:34pm revealed: -There were resident rounding sheets completed at each change of shift where the staff walked the halls together and completed verbal report for each resident; changes were supposed to be discussed during report. -A change in status to include a change in the resident's skin would need to be reported immediately or at change of shift. Observation on 07/10/19 at 8:38am revealed the HWD was looking through Resident #3's record and was unable to locate hospice records or visit notes in the record. Resident #3's hospice records and visit notes dated 07/05/19 were requested on 07/10/19 at 08:35am and 12:26 pm but were not provided prior to survey exit.	{D 273}		