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
	HAL092027	A. BUILDING _____ B. WING _____	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 5-7, 2021.	D 000	This plan of correction is not to be construed as an admission of our agreement with the findings and the conclusions in the Statement of Deficiencies, or any related sanctions or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.	
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide personal care for 1 of 5 sampled residents (#4) who waited for staff assistance between 13 and 56 minutes after utilizing the pendant call system. The findings are: Review of Resident #4's current FL-2 06/28/21 dated revealed: -Diagnoses included edge compression fracture of the fifth lumbar vertebrae, hypertension, atrial fibrillation, depression, anxiety, systolic and diastolic heart failure, gastro-esophageal reflux disease (GERD), and hyperlipidemia. -Resident #4 needed assistance with bathing and dressing. Review of Resident #4's care plan dated 07/31/21 revealed:	D 269	10A NCAC 13F .0901 Personal Care and Supervision: - HWD (or designee) will train all new staff on expectations of responding timely to call bells/ pendants. - HWD (or designee) will monitor the Alarm Response Report daily for three weeks (when in community) and address any non-compliant responses through re-training and/or corrective action as indicated. - After the first three weeks, HWD (or designee) will review the Alarm Response Report weekly for an additional three weeks and address any non-compliant responses through re-training and/or corrective action as indicated. - RCC (or designee) will verify all pagers and pendants are functioning properly on a weekly basis for six weeks.	11/21/2021

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carmen Scott, ED | TITLE: Executive Director | (X6) DATE: 11/16/2021

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D 269	Continued From page 1 -Resident was alert and oriented to person, place and time. -Resident #4 required stand by assistance with dressing and grooming. -Due to her high risk for falls, Resident #4 needed stand by assistance with showering. -She was incontinent of urine. -Resident #4 needed assistance transferring from wheelchair to commode because she was a high risk for falls. -Resident #4 had fallen in the past 12 months. Review of Resident #4's radiology report dated 10/02/21 revealed: -She had an "acute, displaced" fracture of the third finger on her right hand. -There was documentation that Resident #4 was in pain during the x-ray. Review of the facility's alarm response report for October 2021 revealed: -There were columns for name, location, activity, event time, clear time, and response time. -Resident #4 pressed her pendant on 10/01/21 at 11:08am, it was reset at 12:05pm and the response time was 56 minutes. -Resident #4 pressed her pendant on 10/02/21 at 6:07am, it was reset at 6:36am and the response time was 29 minutes. -Resident #4 pressed her pendant on 10/03/21 at 11:06am, it was reset at 11:19am and the response time was 13 minutes. -Resident #4 pressed her pendant on 10/04/21 at 6:36am, it was reset at 7:02am and the response time was 25 minutes. -Resident #4 pressed her pendant on 10/04/21 at 8:21pm, it was reset at 9:05pm and the response time was 44 minutes. -Resident #4 pressed her pendant on 10/05/21 at 12:24am, it was reset at 12:38am and the	D 269		

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response time was 14 minutes.
-Resident #4 pressed her pendant on 10/05/21 at 2:55am, it was reset at 3:12am and the response time was 17 minutes.
-Resident #4 pressed her pendant on 10/05/21 at 7:31am, it was reset at 7:45am and the response was 14 minutes.
-Resident #4 pressed her pendant on 10/06/21 at 2:42am, it was reset at 2:56am, and the response time was 13 minutes.
-Resident #4 pressed her pendant on 10/06/21 at 5:41am, it was reset at 6:08am and the response time was 26 minutes.
-Resident #4 pressed her pendant on 10/06/21 at 11:52am it was reset at 12:11pm, and the response time was 19 minutes.
-Resident #4 pressed her pendant on 10/06/21 at 1:49pm, it was reset at 2:30pm, and the response time was 40 minutes.

Observation of Resident #4 on 10/05/21 at 11:15am revealed:
-Resident #4 sat in a wheelchair and wore a pendant around her neck.
-Resident #4's right third and fourth fingers, hand and partial forearm were in a cast wrapped with an ace wrap.

Interview with Resident #4 on 10/05/21 at 11:15am revealed:
-She resided in the assisted living (AL) unit of the facility.
-She pressed the pendant button when she needed to call staff for assistance.
-There was a string attached to a call system on the wall behind her bed and in the bathroom.
-She usually utilized the pendant button to call staff.
-She had a concern that staff took an extended amount of time to respond when she pressed her

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pendant button.
-During the past weekend on Sunday night, 10/03/21, she needed to use the restroom and pushed her pendant button.
-She thought it took staff 30 minutes to respond to her call and she urinated on herself a couple of times while she waited for assistance.
-She took a diuretic medication that caused her to have urinary urgency.
-When she had to urinate, she had to go to the restroom right away and she could not wait.
-When she had to wait an extended amount of time for staff assistance, she soiled herself.
-On Saturday night, 10/02/21, she fell from her wheelchair and pushed her pendant for staff assistance.
-She thought it took staff one hour and a half to respond.
-There were other days when she waited for staff to respond to her pendant calls and they seemed to be for extended amounts of time.
-It was not the same staff each time and it happened more on weekends evening and night shifts.
-She did not want to get any staff in trouble, she was just concerned that it took a long time for staff to respond.

Review of Resident #4's progress notes revealed:
-Resident #4 fell during night shift on 10/02/21 and had right hand pain.
-There was a note dated 10/02/21 that a virtual visit was setup with Resident #4's primary care provider (PCP).
-A medication aide (MA) spoke with the PCP and an x-ray was ordered.
-There was a note dated 10/03/21 that Resident #4 had a cast on her right hand with two fractures.
-Resident #4 could not use her right hand and

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D 269	Continued From page 4 needed assistance with everything until her fracture was healed. Interview with another AL resident on 10/05/21 at 10:30am revealed: -She thought staff did not respond to pendant calls within a reasonable amount of time. -She had a friend who was a resident who fell, and staff did not respond to her for an hour. -She thought the reason for the extended response times was because there were insufficient amounts of staff. -She was independent and had not waited an extended amount of time for assistance from staff. -She was concerned for other residents who were not able to perform certain tasks for themselves. Observation of a first shift MA in the front lobby on 10/05/21 at 8:45am revealed she answered calls from other staff utilizing a radio and she had a pager attached to her clothing. Interview with the Maintenance Director (MD) on 10/06/21 at 7:20am revealed: -The call bell and pendant system were the same system. -There was a monitor at the front desk receptionist and the monitor showed the location of the call. -The call bell system was reset by pushing a small switch back to the upwards position. -The pendants were reset by pushing the button 3 times, the pendant flashed blue and then a magnet could also be used to reset the pendant. -Some employees had name badges attached to magnets which could be used to reset the pendants. -The front desk receptionist would call staff on the radio when a resident's call was not answered	D 269		

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D 269	Continued From page 5 quickly during the first shift. Interview with the MD on 10/07/21 at 9:41am revealed: -He was told in management meetings that residents had extended wait times for staff to respond to a pendant call or call bell call. -He ordered 8 new pagers and 8 new radios because he inspected the pagers and radios in July 2021. -When he inspected the pagers and radios, he found some of them were missing the back cover or broken. -He also conducted an on-site test by activating a back door and waited for staff to respond in August 2021. -It took staff 15 minutes or more to respond to the location. -Some staff did not know how to read the alert on the pagers, so a class was held with staff to teach them the locations indicated on the pager. -He reported the results of the test to the Administrator. -He also ordered 6 new pagers and 6 new radios 4 or 5 months ago. -He ordered the equipment because some staff told him the equipment was unavailable at the beginning of their shifts in July 2021. -He also replaced the battery pack for the system in July 2021 because the old battery was not working. -He thought a resident should not wait 56 or 29 minutes for assistance and that staff should be accountable for their job responsibilities. -He supervised the housekeeper. Telephone interview with a second shift personal care aide (PCA) on 10/06/21 at 9:00pm revealed: -She worked second shift and there were a total of 3 staff in AL on second shift.	D 269		

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D 269	Continued From page 6 -Staffing for second shift in AL consisted of 1 MA and 2 PCAs. -The MA was assigned to the first and second floor and each PCA was assigned to the first or second floor. -She was oriented by the Administrator and the Health and Wellness Director (HWD) on the facility's policies and protocols, -She was taught in December 2020 that staff should respond to resident pendant calls and call bells within 7 minutes. -Staff did their best to meet this response time. -However, sometimes if she was assisting another resident and she was unable to meet that expectation. -Staff were supposed to radio another PCA or the MA to ask them to take the resident call. -She made rounds every 2 hours for her assigned area. -She would go assist another PCA if they could not answer a resident call and notified her on the radio. -She could not think of a reason why it would take staff 29 or 56 minutes to respond to a resident call. -She did not know Resident #4 waited an extended amount of time for staff to respond to her pendant call. Telephone interview with a second shift MA on 10/06/21 at 10:06pm revealed: -She was oriented by a former staff and she was taught 19 years ago to respond to call bells within 7 minutes. -She did not know of any policy related to answering of the call bells or pendant calls. -She was also told to respond to pendant calls within 7 minutes by the current Administrator and the Resident care Coordinator (RCC) at staff meetings and stand up meetings.	D 269		

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D 269	Continued From page 7 -She knew some residents were waiting an extended amount of time for staff to respond to pendant calls. -She did not know residents were waiting 29 minutes or 56 minutes for staff to respond. -Staff were supposed to obtain a radio and pager at the beginning of their shift. -When a resident, pushed their pendant button or pulled the call bell string staff received an alert on the pager. -Staff were aware of their hall assignments and responded to resident calls within their assigned area. -Staff assignments were made by the RCC. -She thought staff were not responding in 7 minutes because it was not possible if the other personal care aide (PCA) was helping another resident. -Staff were supposed to use their radios to call other staff to respond to resident pendant calls when they were unable to answer the call. -She also thought the residents were waiting an extended amount of time due to a lack of staff. -The facility used to staff the second shift with five staff and now there were three staff for second shift. -Fifty percent of the residents in AL were incontinent and staff did 2 to 3 showers per second shift. -If she had a PCA who took an extended amount of time to respond she spoke with them to determine why it took a long time. -She did not know Resident #4 had waited an extended amount of time for staff to respond to her calls. Telephone interview with a third shift MA on 10/06/21 at 6:41pm revealed: -She worked third shift and was taught to respond to call bells and pendant calls within 5 minutes.	D 269		

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D 269	Continued From page 8 -She was told that resident calls should be answered within 5 minutes by the Administrator, the HWD and the RCC when she was oriented 7 months ago. -She saw that staff did not respond to call bells and pendant calls within 5 minutes. -She observed staff would not have their equipment of a radio and pager with them during the shift. -She thought staff became "tired" of carrying the radio and pager so they would place them down. -When staff did not have a pager, they could not know when a resident called. -She had reported this issue to the RCC and the Administrator, but she could not remember the exact date. -She also thought the additional duties took staff away from resident care such as cleaning the dining room, resetting the dining room tables for breakfast, and laundry. -Forty-five to fifty percent of the 34 residents in AL were incontinent, 4 residents on the 1st floor of AL and 7 residents on the second floor of AL needed assistance ambulating to the toilet. -She thought more staff were needed to respond to resident calls within 5 minutes. -Resident #4 required assistance with toileting, incontinence care now that her right hand was injured from a fall. -She was informed by Resident #4 that it took an extended amount of time for staff to respond to her pendant call. -She spoke with Resident #4 after she was informed of the extended amount of time for staff response. -Resident #4 told her she waited for someone to respond after she fell. -She did not know if staff did not hear the call or if staff was helping another resident. -When Resident #4 waited that long for help, she	D 269		

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began asking and checking to ensure the third shift staff had equipment at the beginning of the shift.
-If she was unable to answer a resident call, she used her radio to call another staff to help the resident.
-Sometimes she received no answer from staff.
-She thought it was a known problem that staff were not responding to resident calls within 5 minutes, because the RCC and HWD came to conduct tests.
-The RCC and HWD came during night shift and conducted tests by opening doors to determine staff's response times.
-She recalled two occasions when the tests were conducted, but staff still did not respond to resident calls within 5 minutes.
-Staff were told in staff meetings to respond to resident calls, but she thought the solution was additional staff were needed to respond to resident calls in a timely manner.

Interview with the RCC on 10/07/21 at 2:48pm revealed:
-She expected staff to respond to resident calls within 10 minutes.
-She knew there was an issue with staff response times to pendant calls and call bells.
-She told staff daily at stand-up meetings with first and second shift staff to respond to resident calls within 10 minutes.
-She taught new staff how to read and use the pagers and radios.
-Staff had said in the past that they did not have equipment, so more radios and pagers were purchased.
-She also told staff to communicate with other staff if they could not answer a resident's call, so that someone else could respond for them.
-She knew Resident #4 fell and broke her right

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middle finger.
-She thought Resident #4 waiting 29 minutes for assistance with toileting was unacceptable.
-She did not know why staff took a long time to respond to Resident #4 and it should not take that long to respond to resident calls.
-There was nothing she could think of that should detain staff for 29 or 56 minutes from responding to a resident call.
-Staff were responsible for ensuring the radio or pager they picked up at the beginning of the shift worked.

Interview with the HWD on 10/07/21 at 3:45pm revealed:
-She expected staff to respond to call bells and pendant calls within 5 to 7 minutes.
-She was aware of what happened with Resident #4 on 10/02/21 and 10/03/21.
-She knew Resident #4 hurt her right hand.
-The Administrator, the RCC and herself were responsible for ensuring staff responded to resident calls within 5 to 7 minutes.
-In the absence of the management team, the MAs were responsible for ensuring staff responded to resident calls.

Interview with the Administrator on 10/07/21 at 4:24pm revealed:
-The facility did not have a policy related to a response time for the pendant/call bell system.
-She expected staff to respond within 10 minutes to all resident calls.
-She made staff aware of her expectations at staff meetings and stand up meetings held twice daily.
-When she received a resident complaint, she investigated the reason for the extended response time.
-She was told in the July 2021 resident council

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meeting that there were extended response times to resident calls.
-New equipment was purchased and she discussed it in the July 2021 staff meeting.
-She had not monitored the staff response times in the past.
-She did not want residents to wait 29 or 56 minutes for staff assistance.
-She did not know the details of Resident #4's extended wait time for staff response on 10/02/21 and 10/03/21.
-She held all staff responsible for ensuring resident calls were responded to within 10 minutes.

Attempted telephone interview with Resident #4's PCP on 10/06/21 at 9:29am was unsuccessful.

Attempted telephone interview with Resident #4's orthopedic provider on 10/06/21 at 8:33am was unsuccessful.

The facility failed to provide personal care for a resident who utilized her pendant to call staff for assistance, waited 29 minutes for staff assistance with toileting resulting in episodes of incontinence, and who utilized her pendant to call staff after falling resulting in a reported 56 minutes wait time for staff to respond. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/06/21 for this violation.

CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 21, 2021.

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D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide personal care for 1 of 5 sampled residents (#4) who waited for staff assistance between 13 and 56 minutes after utilizing the pendant call system. [Refer to Tag D 0269, 10A NCAC 13 F .0901 (a) Personal Care and Supervision (Type B Violation)]	D912		