Received via electronic mail 07/01/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079007	A. BUILDING: ______ B. WING ______	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE REIDSVILLE	2931 VANCE STREET REIDSVILLE, NC 27320

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 06/21/22 through 06/22/22.	D 000	The following is a summary of the plan of correction for Brookdale Reidsville. This Plan of Correction is in regards to the annual survey dated 6/21/22 through 6/22/22. This plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the state of deficiencies, or any related sanction 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 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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#4), including a medication to help reduce fluid overload. The findings are: 1. Review of Resident #4's current FL-2 dated 06/01/22 revealed: -Diagnoses included diastolic congestive heart failure (CHF), chronic atrial fibrillation, chronic obstructive pulmonary disease (COPD), and dementia without behavioral disturbances. -There was an order for an additional dose of Lasix 40mg for weight of 139 pounds or greater. -She was ambulatory with assistance of a rollator. -She received oxygen 3 liters per minute (L/M) continuously. Review of Resident #4's signed physician's orders dated 04/06/22 revealed an order to obtain	D 358	10A NCAC 13F .10049(a) Medication Administration The Executive Director/Health and Wellness Director or Designee will review the medication administration records and weights in PCC daily for 30 days, and then on a random basis for completion of documentation of medications given and weight of resident. Health and Wellness Director will retrain all Medication Aides on documentation of as needed medications and documentation of medication refusal and the need to notifiy doctor when weight changes. Training will be completed by July 15, 2022.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Tracy Holcomb TITLE Executive Director (X6) DATE 6/30/22

Reviewed and acknowledged 07/05/22. SG.

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D 358	Continued From page 1 and record weights each morning on Monday, Wednesday and Friday. Review of Resident #4's electronic medication administration record (eMAR) for April 2022 revealed: -There was an entry to obtain and record weight each morning on Monday, Wednesday and Friday. -There was an entry for an additional dose of Lasix 40mg to be administered for weight of 139 pounds or greater. -There was documentation Resident #4's weight was obtained and recorded each Monday, Wednesday and Friday from 04/01/22 to 04/30/22 with a recorded weight of 139.2 pounds on 04/01/22. -There was no documentation of an additional dose of Lasix administered for weight of 139.2 pounds on 04/01/22. Review of Resident #4's eMAR for May 2022 revealed: -There was an entry to obtain and record weight each morning on Monday, Wednesday and Friday. -There was an entry for an additional dose of Lasix 40mg to be administered for weight of 139 pounds or greater. -There was documentation Resident #4's weight was obtained and recorded each Monday, Wednesday and Friday from 05/01/22 to 05/31/22 with recorded weights as follows: 140.4 on 05/02/22; 142 on 05/04/22; 142.2 on 05/06/22; 141.8 on 05/09/22; 141.2 on 05/11/22; 142 on 05/13/22; 142.4 on 05/16/22; 141.7 on 05/18/22; 139.2 on 05/20/22; 139.2 on 05/23/22; 139.6 on 05/25/22; 139.4 on 05/27/22; 139.8 on 05/30/22. -There was no documentation of an additional dose of Lasix administered for weight greater	D 358		

Division of Health Service Regulation

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than 139 pounds between 5/01/22 and 05/31/22.

Review of Resident #4's eMAR for June 2022 revealed:
-There was an entry to obtain and record weight each morning on Monday, Wednesday and Friday.
-There was an entry for an additional dose of Lasix 40mg to be administered for weight of 139 pounds or greater.
-There was documentation Resident #4's weight was obtained and recorded each Monday, Wednesday and Friday from 06/01/22 to 06/20/22 with recorded weights as follows; 139.8 on 06/01/22; 139.3 on 06/03/22; 141.4 on 06/06/22; 140.8 on 06/8/22; 140.8 on 06/10/22; 139.6 on 06/13/22.
-There was no documentation of an additional dose of Lasix administered for weight greater than 139 pounds between 6/01/22 and 06/13/22.

Observation of weight obtained on 06/22/22 at 9:40am revealed a weight of 138.0 pounds.

Observation of Resident #4's medication on hand on 06/21/22 revealed:
-There was a bubble pack of Lasix 40mg available for administration.
-The instructions on the bubble pack read administer 1 tablet daily as needed for weight of 139 or greater.
-The pharmacy dispensed date was 01/07/22 for 30 tablets.
-There 15 tablets available for administration.

Interview with Resident #4 on 06/22/22 at 10:20am revealed:
-She became short of breath when walking and bathing.
-She did not know what medications she was

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D 358	Continued From page 3 administered. -She wore her oxygen all the time. Interview with a medication aide (MA) on 06/22/22 at 8:15am revealed: -The MAs and the Health and Wellness Director (HWD) were responsible for obtaining and documenting the resident's weights. -Resident #4 was ordered Lasix for fluid retention twice a day and an additional dose for weight of 139 or greater. -The weights would alert the staff of weight gain or fluid retention. -The MA should notify the HWD or the Primary Care Provider (PCP) of significant weight gain; 3 pounds in a day. -Resident #4 would refuse to take her medications occasionally. -She had attempted to administer the additional dose of Lasix, but Resident #4 refused to take the medication. -She did not document on the eMAR that she attempted to administer the Lasix. -She did notify the HWD of Resident's refusal to take the additional dose of Lasix. -She did not document notifying the HWD of Resident #4's refusal to take Lasix. Interview with a MA on 06/22/22 at 8:37am revealed: -The MAs were responsible for obtaining and documenting resident's weights. -Resident's weights were obtained monthly unless ordered more frequently by the PCP. -Resident #4 was administered Lasix for fluid overload. -Resident #4's weight was obtained three times a week to see if she was retaining fluid. -The MA would notify the PCP of Resident #4's weight gain if the weight exceeded the ordered	D 358		

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D 358	Continued From page 4 weight range. -She thought there was an order for Lasix as needed if Resident #4's weight exceeded the ordered weight range. -She thought the weight range to notify the PCP was 140 pounds. -She would document on the eMAR if she administered an as needed medication. -She would have documented in the progress notes of any significant weight gain based on the PCP's orders. -She did not recall administering an additional dose of Lasix to Resident #4. -She did not recall notifying the PCP of Resident #4's weight being greater than 139 pounds. Interview with Resident #4's PCP on 06/22/22 at 9:20am revealed: -He was aware of Resident #4's weight being greater than 139 with no addition Lasix administered. -He realized Resident #4 had gained weight and was not administered addition dose of Lasix upon chart review in May 2022. -He expected the staff to follow orders as written. Interview with HWD on 06/22/22 at 9:05am revealed: -The MAs and HWD were responsible for obtaining and recording resident's weights on the eMAR. -Resident #4 had a diagnosis of CHF and was administered Lasix twice daily and as needed. -Resident #4's weight was obtained on Monday, Wednesday and Friday. -If Resident #4 gained weight, it would represent retention of fluid. -Resident #4 had an order to administer an additional dose of Lasix for weight of 139 or greater.	D 358		

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D 358	Continued From page 5 -She was not aware that the additional dose of Lasix was not being administered to Resident #4 for weight of 139 or greater. -The MA should have administered the additional dose of Lasix to Resident #4 for weight greater than 139. -The MA should have notified Resident #4's PCP of continuous weight greater than 139 pounds. -She expected the MAs to follow orders as written and to document medications administered. Interview with the Administrator on 06/22/22 at 9:33am revealed she expected the MAs to administer medications as ordered.	D 358		T
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure	D 612	10A NCAC 13F .1801 (c) Infection Prevention Control Program (temp) Executive Director, Health and Wellness Director or Designee will enter in daily temperature checks on each residents MAR and will monitor the daily temperature checks and file them in a binder for 30 days, and then on a random basis for completion of documentation of daily temperature of residents. Training to be conducted by the Health and Wellness / Designee to Nurses and medication aides on completing the daily temperatures for monitoring of COVID in the community. Training will be completed by July 15, 2022.	

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recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to 43 residents during the global coronavirus (COVID-19) pandemic as related to daily screening for fever, signs and symptoms of COVID-19.

The findings are:

Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARs-CoV-2 spread in Nursing Homes dated 02/22/22 revealed residents should be evaluated daily for symptoms of COVID-19 and actively monitor residents for fever.

Review of the North Carolina Department of Health and Human Services COVID-19 Post Acute Care Setting Infection Control Assessment and Response (ICAR) tool dated 10/2021 revealed staff and residents should be actively screened daily for fever, signs and symptoms of COVID-19.

Interview with a resident on 06/21//22 at 9:10am revealed:
-The staff checked her temperature when she was sick.
-The staff checked her temperature when she returned from an outing.
-The staff did not check her temperature daily.

Interview with a second resident on 06/21/22 at 9:16am revealed the staff took her temperature about once a week.

Interview with a third resident on 06/21/22 at 9:22am revealed the staff did not check his

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temperature daily.

Interview with a fourth resident on 06/21/22 at 9:30am revealed:
-She could not remember the last time her temperature was checked.
-She thought it was checked about once a month.
-The staff checked her temperature daily when there was a resident with COVID-19 in the facility.

Interview with a fifth resident on 06/21/22 at 9:41am revealed his temperature was not checked daily.

Interview with a personal care aide (PCA) on 06/22/22 at 8:25am revealed:
-The PCAs were not responsible for taking resident's temperatures.
-The MAs were responsible for taking resident's temperatures.
-She did not know how often the resident's temperatures were taken.

Interview with a medication aide (MA) on 06/22/22 at 8:15am revealed:
-Resident's temperature was checked monthly or more frequently when ordered by the Primary Care Provider (PCP)
-The MA, Supervisor-in-Charge (SIC), or the Health and Wellness Director (HWD) were responsible for obtaining the resident's temperatures and documenting the readings on the electronic medication administration record (eMAR).
-The staff were taking the resident's temperatures daily but stopped about 3 months ago.
-She did not remember who instructed the staff to stop taking the resident's temperatures.

Interview with another MA on 06/22/22 at 8:45am

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revealed:
-Resident's temperatures were taken by the MA or SIC.
-Resident's temperatures were taken monthly or as ordered by the PCP.
-The staff stopped taking resident's temperatures daily about 4 months ago.
-The staff checked resident's temperatures daily when there was a COVID-19 outbreak in the facility; an outbreak was 2 or more residents diagnosed with COVID-19 at the same time.
-She did not remember who instructed the staff to stop taking resident's temperatures daily.

Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 8:50am revealed:
-Resident's temperatures were taken daily when there was a COVID-19 outbreak.
-Resident's temperatures were taken daily several months ago, but the staff was instructed that daily temperatures were no longer needed.
-She thought the representative from the local Health Department provided the instruction to stop taking resident's temperatures daily.

Interview with a representative from the local health department on 06/22/22 at 9:25am revealed:
-She was the communicable disease nurse for the county.
-She did not know what the current guidance for checking resident's temperatures in an assisted living facility.
-She had not given the facility any directives regarding resident's temperatures.

Interview with HWD on 06/22/22 at 9:05am revealed:
-The staff checked resident's temperature daily when there was a COVID-19 outbreak.

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D 612	Continued From page 9 -The staff were not taking resident's temperature daily. -She was not aware resident's temperatures needed to be taken daily. Interview with the Administrator on 06/22/22 at 9:33am revealed: -The facility was instructed by corporate that daily resident's temperatures were no longer needed. -She was not aware that resident's temperatures needed to be taken daily.	D 612		