| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345394 | A. BUILDING _____ B. WING _____ | C 08/03/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOK STONE LIVING CENTER | 8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 276 SS=D | 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS<br><br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review the facility failed to complete a quarterly Minimum Data Set (MDS) assessment by the due date for 1 of 6 (Resident #6). The findings included:<br>Resident #6 was admitted to the facility on 3/1/16 with diagnoses which included dementia, hypertension, left hip fracture and depression.<br>A review of the medial record for Resident #6 revealed a 30 day MDS assessment with an Assessment Reference Date (ARD) of 3/29/16.<br>On 8/3/16 at 9:40 AM the MDS nurse stated the last MDS assessment completed for Resident #6 was the MDS assessment with an ARD of 4/26/16. She had not completed any assessment since that one. She stated she needed to check the computer to determine when the MDS assessments were due.<br>On 8/3/16 at 10:27 AM the MDS nurse stated the quarterly MDS assessment for Resident #6 was due on 6/7/16. She stated she just missed doing that assessment.<br>During an interview with the Director of Nursing on 8/3/16 at 12:10 PM she stated she expected the MDS assessments to be completed by the due date. | F 276 | 1) The quarterly assessment for Resident#6 that was due on 6-7-16 was completed on 8-3-16.<br>2) An initial audit will be completed by the MDS nurse or designee on all residents in the facility to ensure that all required MDS assessments were completed by their due date.<br>3) An audit will be completed on all MDS assessments by the MDS nurse/designee to ensure that all required assessment were completed by their due date. This audit will take place weekly x4 weeks then monthly x3 months.<br>4) The results of these audits will be taken to the facility's monthly QA committee meeting. the committee will make recommendations based on the findings of these audits.<br>5)An audit will be done monthly per case mi schedule to ensure all MDS Assessments are completed accordingly. DON will monitor MDS Nurse with case mix schedule. MDS Coordinator will be sent to sister facility for training within next 10 days. | 8/22/16 |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP | F 280 | | 8/22/16 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/22/2016

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345394 | A. BUILDING _____ B. WING _____ | C 08/03/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOK STONE LIVING CENTER | 8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 280 | Continued From page 1<br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review the facility failed to revise the care plan for fall prevention for 1 of 3 residents (Resident #2) reviewed for falls.<br>Findings included:<br>Resident #2 was admitted to the facility on 7/2/15 with diagnoses that included dementia, Parkinson's disease, hypertension and hypothyroidism.<br>The resident's care plan for falls with an onset date of 7/16/15 indicated Resident #2 was at risk for falls due to impaired balance related to his Parkinson's disease with impaired judgement and safety awareness. The goal of receiving no injury was to be attained by providing assistance for all | F 280 | 1) The care plan for Resident #2 was reviewed and updated to include all current fall prevention measures that are in place.<br>2) An initial audit will be performed on all care plans for residents in the facility with fall preventions to ensure that the care plans have been updated to include all current fall prevention interventions that are in place and to ensure that the care plan has been updated at least quarterly.<br>3) An audit will be performed by the MDS nurse/ designee on all fall prevention care plans to ensure that all current fall prevention interventions are listed and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345394 | A. BUILDING _____ B. WING _____ | C 08/03/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOK STONE LIVING CENTER | 8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 280 | Continued From page 2<br>transfers and make sure he's wearing non-skid soled shoes at all times. There had been no revision of the fall care plan and no addition of interventions since 7/16/15.<br>Review of the care card, used by nursing assistants, revealed no fall interventions had been added since the 2015 care plan started.<br>Review of the incident tracking forms for Resident #2, starting in March 2016, indicated fall prevention interventions included adjusting the breaks on the wheelchair, the addition of anti-roll backs for the wheelchair, a mat by the bedside, adding a strip of non-skid tape placed by the bed, reminders not to transfer independently, and review of labs and medications.<br>Resident #2 ' s Annual Minimum Data Set (MDS), with a date of 7/2/16 indicated Resident #2 was severely cognitively impaired, required extensive to total assistance of staff for bed mobility, transfer, toilet use and personal hygiene. The MDS indicated Resident #2 had two or more falls with no injury and one fall with major injury during the assessment period. The resident had received no physical therapy or a restorative nursing program for range of motion or ambulation during the assessment period.<br>An observation was made on 8/2/16 at 3:45 PM. Resident #2 was in a low bed and was actively trying to climb out of bed. A mat was observed on the floor by the bed.<br>At 4:35 PM on 8/2/16, the resident was observed in bed sleeping. The left side of his bed was against the wall and a mat was on the floor on the right side. The bed was in a low position.<br>The Director of Nursing (DON) was interviewed on 8/3/16 at 11:30 AM. The DON stated that each time a resident fell, the MDS nurse was notified with the expectation the care plan would be updated with the new interventions. The | F 280 | that the care plan has been updated at least quarterly. this audit will take place weekly x4 weeks then monthly x 3 months.<br>4) The results of these audits will be taken to the facility's monthly QA committee meeting. The committee will make recommendations based on the findings of these audits.<br>5) DON will complete initial audit to ensure care plans are done correctly and in a timely manner. DON/Administrator will review with Quality Assurance team all audits completed and accurately every month. DON will in-service MDS Nurse on updating care plans per incident reports on a daily basis as they occur. A copy of the incident report will be given to MDS Coordinator to update resident care plans accordingly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345394 | A. BUILDING _____ B. WING _____ | C 08/03/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOK STONE LIVING CENTER | 8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 280 | Continued From page 3<br>DON reviewed the care plan for Resident #5 and acknowledged the start date was 7/16/15 and had not been revised since.<br>On 8/3/16 at 12:26 PM, the MDS nurse was interviewed. She stated generally revisions to a care plan were made quarterly when the care plan was reviewed or made after discussions at the morning meetings. The MDS nurse stated if a resident, such as Resident #2 had a lot of falls, the care plan would be reviewed after the fall to review the effectiveness of the interventions and to add new interventions as needed. After the MDS nurse reviewed the fall care plan for Resident #2, she stated the onset date for the fall care plan was 7/16/15 and acknowledged the care plan had not been revised since 2015. The MDS nurse agreed with Resident #2 sustaining 10 falls since March 2016, the interventions on the care plan were not working. She was unaware of any interventions being used to prevent falls other than what was stated on the care plan. | F 280 | | |