DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED
		345209	B. WING		07/11/2019
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
PROOKE	DGE RETIREMENT COM		1	199 HAYES FOREST DRIVE	
BROOKKI	DGE RETIREMENT COM		N	WINSTON-SALEM, NC 27106	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
E 000	Initial Comments		E 000		
F 641 SS=D	conducted on 7/8/19 was found in complia CFR 483.73, Emerge #IH4D11. Accuracy of Assessm	certification survey was through 7/11/19. The facility nce with the requirement ency Preparedness. Event ID nents	F 641		8/8/19
	resident's status. This REQUIREMENT by:	t accurately reflect the			
	facility failed to accur Data Set (MDS) asse	iew and staff interview, the ately code the Minimum ssments for antidepressant of 1 resident (Resident #29) zation.		 Resident #29 was discharged from Brookridge Retirement Community on 05/08/2019. Nursing management will audit 100 MDS assessments completed in the la 90 days for antidepressant medication 	% of Ist
	Findings included:			coding accuracy by 08/08/2019. Any assessments identified as having	
				 antidepressant medication coding inaccuracy for current residents will be modified by 08/08/2019 by nursing management. 3. The MDS Nurse will be in-serviced antidepressant medication assessment 	on
	(MDS) assessment d Resident #29 had im required one-person activities of daily livin	ssion Minimum Data Set ated 4/18/19 revealed paired cognition and extensive assistance for g. It did not state that the antidepressant or have a		 coding accuracy by the Director of Nursing (DON) by 08/08/2019. 4. Nursing management will monitor antidepressant medication coding accuracy on all transmitted MDS 	
	diagnosis of depressi Review of Resident #	•		assessments weekly x 3 months. All results will be brought to weekly review meetings by nursing management. All results will be brought to QAPI by Nurs Management for review quarterly.	
		SUPPLIER REPRESENTATIVE'S SIGNATUR	۲E	TITLE	(X6) DATE
Electroni	cally Signed				07/24/2019

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION		D. 0938-039 SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	` ,		· · ·	PLETED		
		345209	B. WING		07	/11/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
BROOKR	IDGE RETIREMENT COM	IMUNITY		1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE		
F 641	Continued From page	e 1	F 64					
	antidepressant therap	ру.						
	Review of physician orders revealed an order for Resident #29 to take Prozac 20mg daily on his admission to the facility.			5. The titles of the persons respon implementing the acceptable plan correction are MDS, RN Superviso	of			
		29's medication revealed the resident g daily from 4/11/19 to						
	7/9/19 at 3:41 PM sh MDS from 4/18/19 sh 7 days of antidepress and that would have the MDS nurse to init antidepressant/psych expected that both ca	otropic care plan. It is						
F 656	of Nursing. They bot expectation that both care plans both accu antidepressant use.	dministrator and the Director h stated that it is their MDS assessments and	F 656			8/8/19		
SS=D		-						
	implement a compret care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timefra	cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and						

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FOR	D: 08/08/2019 MAPPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATI	E SURVEY PLETED
	345209	B. WING		07	/11/2019
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
			1199 HAYES FOREST DRIVE		
BROOKRIDGE RETIREMENT COM			WINSTON-SALEM, NC 27106		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
 assessment. The condescribe the following (i) The services that is or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, inclust treatment under §483.10, inclust treatment under §483. (iii) Any specialized as rehabilitative services provide as a result of recommendations. If findings of the PASA rationale in the resident's representat (A) The resident's go desired outcomes. (B) The resident's profiture discharge. Fact whether the resident's community was assel local contact agencies entities, for this purper (C) Discharge plans plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on staff interviation for the provide of the pro	fied in the comprehensive mprehensive care plan must g - are to be furnished to attain ent's highest practicable d psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). services or specialized s the nursing facility will f PASARR a facility disagrees with the RR, it must indicate its ent's medical record. th the resident and the tive(s)- als for admission and eference and potential for cilities must document 's desire to return to the essed and any referrals to as and/or other appropriate	F	 1. Resident #27 discharged from Brookridge Retirement Communu/04/18/2019. Resident #29 discharged from 	nity on	

Facility ID: 922961

		MEDICAID SERVICES				O. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · ·	e survey Ipleted	
		345209	B. WING		07/11/2019		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
BROOKR	IDGE RETIREMENT CO	MMUNITY		1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 656	Continued From pag	e 3	F 6	56			
	 Continued From page 3 addressed antidepressant medication use for 1 of 1 resident (Resident #29) reviewed for hospitalization. Findings included: Resident #27 was admitted to the facility on 3/29/19 with diagnoses that included, in part, hypertension and heart block. Resident #27 discharged home on 4/18/19. A review of the admission Minimum Data Set (MDS) assessment dated 4/5/19 revealed Resident #27 had moderately impaired cognition. Further review of the MDS assessment revealed active discharge planning was in place for Resident #27. A review of the care plan updated 4/12/19 revealed there was no care plan that addressed discharge planning. On 7/10/19 at 10:20 AM an interview was completed with the Social Worker. She stated she assisted residents with the discharge planning process but typically had not completed any care plans that addressed discharge planning. The Social Worker said the MDS Nurse completed all the care plans. On 7/10/19 at 10:42 AM an interview was completed with the Former MDS Nurse. She said discharge planning information was documented in the interdisciplinary notes. She stated discharge planning information was documented in the interdisciplinary notes. She stated discharge planning was not included in the comprehensive care plan and said she was unaware of the regulation that discharge goals and plans were supposed to be addressed in the 			 2. Nursing management will aud all current residents' care plans f discharge goals by 08/08/2019. <i>J</i> plans identified as not having dis goals will be modified to include goals by nursing management by 08/08/2019. Nursing management will audit 1 residents with a current physicial receive antidepressant medicatio care plans addressing antidepres medication use by 08/08/2019. <i>A</i> resident care plans identified as addressing antidepressant medicatio for residents with a current physic order for antidepressant medicatio be modified to include antidepres medication use by nursing mana by 08/08/2019. 	or Any care charge discharge y 00% of n order to ons for ssant ony not cation use cian ion will ssant		
				 3. The MDS Nurse was in-servic care planning discharge goals by on 07/15/2019. The MDS Nurse was in-serviced planning antidepressant medication physician orders by t on 07/15/2019. 4. Nursing management will mor 100% of new admission care pla discharge goals weekly x 3 mont results will be brought to weekly meeting by nursing management results will be brought to QAPI b Management for review quarterly 	y the DON on care ion use he DON hitor ns for hs. All review t. All y Nursing		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/08/2019 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		345209	B. WING			07/	11/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKRI	DGE RETIREMENT COM	MUNITY			199 HAYES FOREST DRIVE VINSTON-SALEM, NC 27106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	discharge planning ha electronic medical rec expected discharge p in a resident's compre 2. Resident #29 was a 4/11/19 with diagnose traumatic brain dysfur discharged to the hos surgery on 5/8/19. A review of the admis (MDS) assessment da Resident #29 had imp required one-person of activities of daily living resident received an a diagnosis of depression Review of Resident # summary revealed the antidepressant therap Review of physician of Resident #29 to take admission to the facilit Review of Resident # administration record received Prozac 20m 4/18/19. Review of Resident # there was no care pla	M an interview was dministrator. She stated ad not been included in the cord care plan and said she lans and goals be included ehensive care plan. admitted to the facility on es that included, in part, notion. Resident #29 pital for a scheduled sion Minimum Data Set ated 4/18/19 revealed baired cognition and extensive assistance for g. It did not state that the antidepressant or have a on. 29's hospital discharge e resident was on chronic by. orders revealed an order for Prozac 20mg daily on his ty. 29's medication revealed the resident g daily from 4/11/19 to 29's care plan revealed	F	656	5. The titles of the persons responsible implementing the acceptable plan of correction are MDS, RN Supervisor, D		
	Resident #29 had imp required one-person of activities of daily living resident received an a diagnosis of depression Review of Resident # summary revealed the antidepressant therap Review of physician of Resident #29 to take admission to the facilit Review of Resident # administration record received Prozac 20m 4/18/19. Review of Resident # there was no care pla	paired cognition and extensive assistance for g. It did not state that the antidepressant or have a on. 29's hospital discharge e resident was on chronic by. orders revealed an order for Prozac 20mg daily on his ty. 29's medication revealed the resident g daily from 4/11/19 to 29's care plan revealed n that addressed					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
		345209	B. WING			07/	11/2019	
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
BROOKRI	DGE RETIREMENT COM	MUNITY			199 HAYES FOREST DRIVE VINSTON-SALEM, NC 27106			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 656 F 657 SS=D	During an interview w 7/9/19 at 3:41 PM she MDS from 4/18/19 sh 7 days of antidepress and that would have to the MDS nurse to initi antidepressant/psych expected that both car assessments address On 7/10/19 at 4:33 Pf completed with the Ac of Nursing. They both expectation that both care plans both accur antidepressant use. Care Plan Timing and CFR(s): 483.21(b)(2)(§483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prace the resident and the r An explanation must f medical record if the p	ith the MDS Nurse on e stated that Resident #29's ould have documented the ant medication administered riggered the system to alert iate an otropic care plan. It is re plans and MDS a antidepressant use. M an interview was dministrator and the Director in stated that it is their MDS assessments and rately address Revision (i)-(iii) ensive Care Plans orehensive care plan must days after completion of seessment. erdisciplinary team, that ited to visician. e with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined		656			8/8/19	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/08/20 FORM APPROVE OMB NO. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345209	B. WING		07/11/2019
NAME OF PR	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
			1'	199 HAYES FOREST DRIVE	
BROOKRI	DGE RETIREMENT CON	IMUNITY	v	VINSTON-SALEM, NC 27106	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CO CY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO R LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THI DEFICIENCY DEFICIENCY			LD BE COMPLETION
F 657	disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and of assessments. This REQUIREMENT by: Based on observation interviews and record update the care plan interventions in the a 4 residents (Resident Resident #17) review Findings included: 1. Resident #15 was 3/14/18 with diagnost Alzheimer's disease. Resident had severe of required one person transfers and walking revealed Resident #1	e staff or professionals in ined by the resident's needs ie resident. rised by the interdisciplinary assment, including both the quarterly review T is not met as evidenced ons, resident and staff d review, the facility failed to with appropriate rea of fall prevention for 3 of t #15, Resident #19 and ved for accidents. admitted to the facility on es that included, in part, erly Minimum Data Set lated 5/31/19 revealed cognitive impairment. She limited assistance for g. Further review of the MDS 15 had one fall with injury in	F 657	 The fall care plan for resident #1 reviewed and updated by nursing management to reflect appropriate intervention on 08/01/2019. The fall care plan for resident #17 v reviewed and updated by nursing management to reflect appropriate intervention on 08/01/2019. The fall care plan for resident #19 v reviewed and updated by nursing management to reflect appropriate intervention on 08/01/2019. The fall care plan for resident #19 v reviewed and updated by nursing management to reflect appropriate intervention on 08/01/2019. A 100% audit of fall care plans for residents having falls in the month will be reviewed by nursing manage for appropriate intervention by 08/08/2019. Any resident care plan identified as not addressing approp fall intervention for residents with fa during the month of July will be uppo- include appropriate fall intervention 	fall was fall was fall or of July ement s priate alls dated to
	awareness and deme "Will not experience a injuries." Care plan a "Observe for unstead ambulation and provi	approaches included, ly/unsafe transfers or de stand-by or balance		 nursing management by 08/08/201 3. The MDS nurse was in-serviced DON on 07/15/2019. 4. 100% of falls will be reviewed for 	by the
	support as needed, n	nonitor resident for signs of		appropriate intervention placement	on the

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		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVEI O. 0938-039 ⁻		
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345209	B. WING _		07	//11/2019		
NAME OF PF	OVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE,	ZIP CODE			
BBOOKBI				1199 HAYES FOREST DRIVE				
BROOKKI	JGE RETIREMENT COM			WINSTON-SALEM, NC 2710	06			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 657	Continued From page	e 7	F6	657				
	deficits and accommon regarding safety devi- risks." A care plan ap- revealed, "Education on signs and sympton handle certain behav- resident is awake to a On 7/8/19 at 2:03 PM #15 revealed she was prevention floor mats of the bed. An intervi- family member revea of months ago and fra- family member was u- circumstances that su A review of an incider revealed, "Certified N- reported to this writer resident down the ha away from her, lost h stated this resident h the hall banister. Thi resident. No raised a a small skin tear just Cleansed with norma ointment, and covere responsible party. In book. Staff to do free to monitor."	ces and environmental pproach updated 10/25/18 provided to staff and spouse ms of agitation and how to iors, and to be alert while avoid falls and/or injuries." I an observation of Resident is in her bed resting. Fall were placed on either side iew with Resident #15's led the resident fell a couple actured her wrist but the inable to recall the urrounded the fall. Int report dated 5/1/19 lursing Assistant (CNA) that she was walking this II and this resident pulled er balance and fell. CNA it the back of her head on s writer assessed this areas found at this time. Has below the left elbow. I saline, applied anti-biotic d with bandaid. Notified doctor communication quent checks. Will continue		residents' care plans w by nursing management brought to weekly revie nursing management. / brought to QAPI by nur for review quarterly. 5. The titles of the pers implementing the accep correction are MDS, RM	nt. All results will be ew meeting by All results will by rsing management sons responsible for ptable plan of			
	-	tion interventions were n after Resident #15 fell on						
	On 7/11/19 at 1:09 Pl	M an interview was						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 08/08/2019 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY
		345209	B. WING			07/ [,]	11/2019
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
BROOKRI	DGE RETIREMENT COM	MUNITY		199 HAYES FOREST DRIVE			
			\ `	WINSTON-SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 657	said she walked with and when the residen resident's room NA #7 Resident #15 who the and fell. NA #1 said s Resident #15 fell into but recalled the reside the fall. NA #1 report the nurse after Reside On 7/10/19 at 1:51 PM completed with Nurse typically walked arour most days but had tim unbalanced and requi stated when she arriv Resident #15 fell she wrist as swollen, notif obtained an x-ray. Nur revealed a fractured w scheduled for treatme orthopedic rehabilitati sent to the emergency complained of pain. On 7/10/19 at 8:22 AM completed with the Di She stated whenever investigation of the fai of the incident. She s team met daily and di previous day and fall	 Aide (NA) #1. She 15's fall on 5/1/19. NA #1 Resident #15 in the hallway t tried to go into another 1 attempted to redirect en pulled away from NA #1 she could not remember if the wall, door or on the floor ent used her arm to break ed she immediately notified ent #15 fell. M an interview was e #1. She said Resident #15 nd the unit with a steady gait nes when she became ired supervision. Nurse #1 ed for her shift the day after assessed the resident's ied the physician and urse #1 said the x-ray vrist. Resident #15 was ent of the wrist fracture at an on office but was instead y room since she 	F 657		EFICIENCY)		
	hours of a fall. On 7/10/19 at 11:30 A						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/08/2019 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE	
		345209	B. WING			07/	11/2019
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKRI	IDGE RETIREMENT COM	MUNITY			1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 657	24-48 hours by the M or DON. On 7/10/19 at 3:29 Pf completed with the Df had several different f eight months and the been in her role for or stated Resident #15's been updated after th acknowledged care p facility had identified i and Performance Imp 2. Resident #19 was 2/24/18 with diagnose anemia and Parkinson Resident #19's quarte (MDS) assessment da resident was cognitive person limited assista a wheelchair. Further revealed Resident #1 no injury in the look b assessment. A review of the curren problem of, "At risk fo falls," and a stated go major fall related injur updated 7/31/18 reve resident to not bend of wheelchair, to call for dropped items." A ca 8/12/18 revealed, " used will be kept with	e plan was updated within DS nurse, nurse supervisor M a follow up interview was ON. She said the facility MDS nurses in the past current MDS nurse had hly a few weeks. The DON is care plan should have the fall on 5/1/19. She lans had been an issue the in their Quality Assessment provement process. admitted to the facility on the sthat included, in part, n's disease. erly Minimum Data Set ated 6/14/19 revealed ely intact. She required one ance for transfers and used r review of the MDS 9 had two or more falls with ack period of the and of, "Will not have any ries." A care plan approach	F	657			

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	-					FORM): 08/08/2019 1 APPROVED
STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345209	B. WING		_	07/	11/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
BROOKRI	DGE RETIREMENT COM	MUNITY		199 HAYES FOREST DRI ^N VINSTON-SALEM, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	 prior to transferring or On 7/8/19 at 3:47 PM with Resident #19. S of weeks ago when sl something up off the fl wheelchair. A review of an incider revealed, "Certified N answered resident's of sitting upright in the fl wheelchair. 'I was be book up off the floor.' incident: Head to toe Large raised area to t forehead noted. Resi hospital. Neuro check reminded not to bend use call light for assis transfers" Further review of the additional fall prevent added to the care plane 6/26/19. On 7/10/19 at 8:51 AR completed with Nurse nurse on duty 6/26/19. She reported Resider bent over to pick up a and hit her head. On 7/10/19 at 8:22 AR 	"Reminded and to always call for assistance r standing." an interview was completed he reported she fell a couple he attempted to pick floor while she sat in her th report dated 6/26/19 ursing Assistant (CNA) call light and located resident oor in front of her ending over trying to pick a Staff action at time of assessment administered. the left side of resident's ident refuses to go to the ks initiated. Resident over in wheelchair and to tance with toileting and care plan revealed no ion interventions were n after Resident #19 fell on M an interview was e #1. She said she was the ownen Resident #19 fell. th #19 was in her wheelchair, book, fell out of the chair M an interview was irector of Nursing (DON).	F 657				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 08/08/2019 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION		(X3) DATE	
		345209	B. WING				07/	11/2019
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
BROOKR	IDGE RETIREMENT COM	MUNITY			1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE		(X5) COMPLETION DATE
F 657	of the incident. She s team met daily and di previous day and fall were added to the res hours of a fall. On 7/10/19 at 11:30 A completed with the Ad a resident fell the care 24-48 hours by the M or DON. On 7/10/19 at 3:29 Pt completed with the Du had several different I eight months and the been in her role for or stated Resident #19's been updated after th acknowledged care p facility had identified i and Performance Imp 3. Resident #17 was 2/22/19 with diagnose Alzheimer's disease a Resident #17's quarte (MDS) assessment da resident was cognitive one-person extensive and used a wheelcha MDS revealed Reside with no injury in the lo assessment. Review of incident rep	II was completed at the time said the interdisciplinary scussed falls from the prevention interventions sident's care plan within 24 AM an interview was dministrator. She said when e plan was updated within DS nurse, nurse supervisor M a follow up interview was ON. She said the facility MDS nurses in the past current MDS nurse had hly a few weeks. The DON care plan should have e fall on 6/26/19. She lans had been an issue the n their Quality Assessment provement process. admitted to the facility on es that included, in part, and dementia. erly Minimum Data Set ated 6/6/19 revealed ely impaired. She required e assistance for transfers ir. Further review of the ent #17 had two or more falls	F	657				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/08/2019 MAPPROVED	
STATEMENT OF DEFICIENCIES (X1) PRO		(X1) PROVIDER/SUPPLIER/CLIA (X2			E CONSTRUCTION	(X3) DATE	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345209	B. WING			07/	/11/2019	
NAME OF PI	ROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 000		
PROOKE	DGE RETIREMENT COM		1199 HAYES FOREST DRIVE					
BROOKKI	DGE RETIREMENT COM			V	WINSTON-SALEM, NC 27106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 657	Continued From page 5/31/19.	e 12	F	657	7			
	problem of, "At risk for history and decrease goal of, "resident will falls through next revi updated 3/21/19 reve use the call bell for as approach updated on monitored by staff at a A care plan approach problem of, "At risk for non-compliance with with the intervention of the importance of req ADL's". During an interview w 7/10/19 at 4:12 PM st was confused, she tri wheelchair frequently monitored more close resident did not use h During an interview w 4:16 PM she stated th oriented and was con tried to go to the bath and staff have to more	assistance to the bathroom" of "re-educated resident on uesting assistance for with Nurse Aide #2 on he stated that Resident #17 ed to get up from her and that she has to be ely. She stated that the her call bell often, if at all. with Nurse #1 on 7/10/19 at hat Resident #17 was not fused. She stated that she room on her own at times hitor her closely.						
	She stated whenever investigation of the fa of the incident. She s team met daily and di previous day and fall	irector of Nursing (DON).						

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	D: 08/08/2019 MAPPROVED	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345209	B. WING		_	07/	11/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE			
BROOKRI	DGE RETIREMENT COM	MUNITY		1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE	
F 657 F 761 SS=D	hours of a fall. She si interventions to be inc and that providing edu resident was not an a also stated that the or monitored by staff at a one on one sitter, Res one on one sitter, Res one on one sitter, so t appropriate either. On 7/11/19 at 4:40 PM completed with the Ac They said when a res expectation the care p 24-48 hours by the M or DON with appropria resident. Label/Store Drugs an CFR(s): 483.45(g)(h)(§483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the e applicable. §483.45(h) Storage of §483.45(h)(1) In acco Federal laws, the faci biologicals in locked of temperature controls, personnel to have acco	tated that she expected the dividualized to each resident ucation to a confused ppropriate intervention. She hly way a resident can be all times was if they had a sident #17 had not had a that intervention was not <i>M</i> an interview was dministratorand and DON. ident fell, it was their blan was updated within DS nurse, nurse supervisor ate interventions for each d Biologicals (1)(2) of Drugs and Biologicals used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized	F 65				8/8/19	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345209		. ,	(X3) DATE SURVEY COMPLETED			
		B. WING	07/11/2019			
NAME OF PROVIDER OR SUPPLIER BROOKRIDGE RETIREMENT COMMUNITY			TREET ADDRESS, CITY, STATE, ZIP CODE			
			1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			
Continued From page	ge 14	F 761				
 Continued From page 14 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications and blood glucose test strips, date and label multi-dose eye ointment when opened, and ensure there were no loose pills in medication/treatment carts and one of one medication rooms observed. The findings included: Observations on 7/11/19 at 10:20 AM of the medications: 1 - Miralax powder bottle (Expired 11/2018), 1 - Vaseline gauze (Expired 7/2018), and 1 - opened bottle of blood glucose strips (Expired 9/30/2018). In the top drawer of the cart, there was a loose white oblong pill, and an opened multi-use Lubrifresh PM eye ointment tube that was not labeled or dated. 			 The expired Miralax powder be expired Vaseline gauze, open bod blood glucose strips, white oblong open multiuse Lubifresh PM eye tube were removed from the 600 medication care and disposed of nursing management on 07/11/20 15 expired triple ointment packets expired bacitracin zinc ointment p were removed from the 600 hall medication room and disposed of nursing management on 07/11/20 A 100% audit of all medication treatment carts and medication ro was completed by nursing manage on 07/15/2019. Any medications/ treatment supplies identified as lo expired or open without proper la dating was removed and dispose 	ttle of g pill and ointment hall by 019. The s and backet 5 by 019. carts, booms gement bose, beling or		
Observations of the residents at 7/11/19 expired Triple Antibi	medication room for 600 Hall at 10:32 AM revealed 15 otic Ointment Packets (0.9g		3. A 100% in-service of nurses ar medication aides will be complete nursing management on the prop labeling and storage of drugs and biologicals by 08/08/2019.	nd ed by er		
F	CORRECTION ROVIDER OR SUPPLIER IDGE RETIREMENT CO SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From page storage of controlled the Comprehensive Control Act of 1976 abuse, except when package drug distrit quantity stored is m be readily detected. This REQUIREMEN by: Based on observati facility failed to remo blood glucose test s multi-dose eye ointr ensure there were n medication/treatmen medication/treatmen medication/treatmen medication/treatmen medication/treatmen medications on 7/1 medications on 7/1 medi	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345209 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications and blood glucose test strips, date and label multi-dose eye ointment when opened, and ensure there were no loose pills in medication/treatment carts and one of one medication rooms observed. The findings included: Observations on 7/11/19 at 10:20 AM of the medications: 1 - Miralax powder bottle (Expired 11/2018), 1 - Vaseline gauze (Expired 7/2018), and 1 - opened bottle of blood glucose strips (Expired 9/30/2018). In the top drawer of the cart, there was a loose white oblong pill, and an opened multi-use Lubrifresh PM eye ointment tube that was not labeled or dated. Observations of the medication room for 600 Hall residents at 7/11/19 at 10:32 AM revealed 15 expired Triple Antibiotic Ointment Packets (0.9g weight), and 1 - Bacitracin Zinc Ointment Packet	CORRECTION IDENTIFICATION NUMBER: A. BUILDING_ 345209 B. WING	CORRECTION DENTFICATION NUMBER. A BUILDING 345209 B. WING ROWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE DGE RETIREMENT COMMUNITY STREET ADDRESS, CITY, STATE, ZIP CODE IMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) ID PREVICE TAGE CONTROL CORRECTIVE CONSTRUCTIVE CONSTRUCTION (EACH CORRECTIVE CONSTRUCTIVE CONSTRUCTION) Continued From page 14 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and Other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. F 761 This REQUIREMENT is not met as evidenced by: 1. The expired Miralax powder D expired Vaseline gauze, open bo blood glucose test strips, date and label multi-dose eye ointment when opened, and ensure there were no loose pills in medication/treatment cart for one of one medication room sobserved. 1. The expired Miralax powder D to the COD medication/treatment cart used for 600 Hall medication room and disposed of nursing management on 07/11/2 15 expired triple ointment packet expired triple ointment packet expired triple ointment packet expired triple ointment packet expired triple ointment packet sequired solution for the 00 hall medication room and lapposed of the cart, there was a loase white oblong pill, and an opened multi-use Lubifresh PM eye ointment tube that was not labeled or dated. 3. A 100% in-service of nurses ar medication aides will be complete sexpired Triple Antibiotic		

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345209		(X2) MULTIPL	OMB NO. 0938-03			
		IDENTIFICATION NUMBER.	A. BUILDING	COMPLETED		
		B. WING	07/11/2019			
NAME OF PROVIDER OR SUPPLIER BROOKRIDGE RETIREMENT COMMUNITY			;			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		OULD BE COMPLETI	
F 761	nursing staff was resp and the medication re and supplies. During an interview w 7/11/19 at 11:20 AM, expectation that there medications or suppli rooms. She stated th was hired to audit me been signing off weel that they were check and supplies. She st	ponsible for checking carts for for expired medications with the Administrator on she stated that it was her e were no expired ies in the carts or medication hat a pharmacy company edication storage and had kly for the last few weeks ed for expired medications ated that in between those pectation that third shift	F 761	and medication storage rooms w reviewed for proper labeling and of drugs and biologicals weekly o months. All results will be brough weekly review by nursing manage All results will be brought to QAF nursing management for review 5. The title of the persons respor implementing the acceptable pla correction are supervisors.	storage < 3 ht back to lement. Pl by quarterly. hsible for	

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