	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		(X3) DATE S COMPL	
		345066	B. WING		C	
	OVIDER OR SUPPLIER	343066		STREET ADDRESS, CITY, STATE, ZIP CODE	12/0	2/2021
NAME OF F	OVIDER OR SOFFLIER			4748 OLD SALISBURY ROAD		
ALSTON E	ROOK			LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000	D		
	conducted 11/29/21 to was found in complia	certification survey was hrough 12/2/21. The facility nce with the requirement ncy Preparedness. Event				
F 000	INITIAL COMMENTS		F 000	0		
		complaint investigation was 0/21 to 12/2/21. Event ID#				
F 550 SS=D	5 of the 7 complaint a substantiated resultin Resident Rights/Exer CFR(s): 483.10(a)(1)	g in deficiencies. cise of Rights	F 55(ס		12/30/21
33-0	§483.10(a) Resident The resident has a rig self-determination, ar access to persons an	Rights. ght to a dignified existence, nd communication with and				
	with respect and dign resident in a manner promotes maintenance	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and				
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all				

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.

12/16/2021

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	M APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345066	B. WING			C /02/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•			
ALSTON I	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
F 550	residents regardless of §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The res free of interference, c reprisal from the facilit rights and to be supple exercise of his or her subpart. This REQUIREMENT by: Based on observatio interviews, the facility over a urinary drainage reviewed with indwell (Resident #184). The findings included Resident #184 was an 11/18/21 with diagnost fracture, retention of the Review of the nursing on 11/19/21, Residen urinary catheter place The admission Minim assessment dated 11	of payment source. of Rights. right to exercise his or her if the facility and as a citizen ted States. cility must ensure that the his or her rights without a, discrimination, or reprisal sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this ' is not met as evidenced ns, record review and staff failed to provide a cover ge bag for 1 of 4 residents ing urinary catheters : dmitted to the facility on ses that included a right hip urine and diabetes type 2. g progress notes indicated t #184 had an indwelling ed due to difficulty voiding.	F 5	50 ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISH FOR THOSE RESIDENTS FOUND HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. On November 30, 2021 a Urinary Drainage Bag cover was placed or Resident #184 Urinary Drainage B Nursing staff have been re-educate Residents Rights regarding Dignity conjunction with proper placement Urinary Drainage Bag covers. ADDRESS HOW THE FACILITY V IDENTIFY OTHER RESIDENTS H THE POTENTIAL TO BE AFFECT THE SAME DEFICIENT PRACTIC	D TO ag. All ed on r in of VILL AVING ED BY			

Facility ID: 923187

If continuation sheet Page 2 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/06/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345066	B. WING _				C 02/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				474	48 OLD SALISBURY ROAD		
ALSTON E	ROOK			LE	EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	extensive assistance from staff for toileting needs		F 5	50	An audit of four other residents in the		
	made of Resident #18 She was noted to hav attached to the footre	urinary catheter. AM, an observation was A sitting in a recliner chair. The a urinary drainage bag st of the recliner chair, er, which could be seen from			facility with Urinary Drainage Bags wa conducted on November 30, 2021 by Director of Nursing to ensure Urinary Drainage Bag cover was in place. On December 3, 2021 all Nursing staff we re-educated on Residents Rights regarding Dignity in conjunction with proper placement of Urinary Drainage Bag covers.	the ere	
	11/30/21 at 9:40 AM. was hanging on the ri privacy cover and was Another observation of PM while Resident #1 urinary drainage bag hanging on the right s privacy cover in place Nurse Aide (NA) #6 w at 4:00 PM and stated been assisted back to drainage bag privacy the wheelchair. She w with urinary catheters privacy bag present of wheelchair if they wer were working with the	as interviewed on 11/30/21 d Resident #184 had just b bed and the urinary cover was still attached to vent onto explain residents would normally have a n the bed as well as the re able to get out of bed and trapy as was Resident #184.			ADDRESS WHAT MEASURES WILL PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THA THE DEFICIENT PRACTICE WILL NE RECUR. All Nursing staff were re-educated on proper placement of Urinary Drainage Bag covers on December 3, 2021. All Nursing staff is required to receive the Urinary Drainage Bag covers prior to assuming their work assignments. Education was completed by the Staff Development Nurse. Any new employ will be trained in Employee Orientatio The Director of Nursing or Designee we check proper placement and proper covering for all Urinary Drainage Bag ensure resident rights are protected an pertains to Dignity practices.	F DT eees n. vill s to	
	on 11/30/21 at 4:30 P with urinary catheters	with the Director of Nursing M. She explained residents should have a privacy bag and normally a privacy ce to the bed and the			INDICATE HOW THE FACILITY PLAT TO MONITOR ITS PERFORMANCE MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Director of Nursing or Designee w monitor proper placement and proper	ТО <u>=</u>	

Event ID: KV8T11

Facility ID: 923187

If continuation sheet Page 3 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/06/2022 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345066	B. WING		12/02/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1
ALSTON E	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	
(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 SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 550			F 55	 cover for all Urinary Drainage Bag ensure resident rights as pertains Dignity practices are being protect monitoring will be conducted as for 1. Monitor all Urinary Drainage B days per week for four (4) weeks; 2. Monitor all Urinary Drainage B days per week bi-weekly for four (weeks; then 3. Monitor all Urinary Drainage B monthly until resolved by the Qual Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Ass Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRET ACTION WILL BE COMPLETED. All training/re-education will be co by December 30, 2021. 	to ted. The illows: Bags 2 then Bags 2 4) Bags lity of essurance
F 638 SS=D	CFR(s): 483.20(c) §483.20(c) Quarterly A facility must assess quarterly review instr and approved by CM once every 3 months	s a resident using the ument specified by the State S not less frequently than	F 63	38	12/30/21
	Based on record rev facility failed to asses quarterly Minimum D	iew, and staff interview, the s and to complete a ata Set (MDS) assessment s following the previous		ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISE FOR THOSE RESIDENTS FOUN HAVE BEEN AFFECTED BY THE	D TO

Facility ID: 923187

If continuation sheet Page 4 of 75

	-	ID HUMAN SERVICES				FORM	APPROVED 0.0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345066	B. WING _				C 02/2021	
NAME OF P	ROVIDER OR SUPPLIER	I	STREET ADDRESS, CITY, STATE, ZIP CODE					
ALSTON	BROOK				48 OLD SALISBURY ROAD EXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 638	assessment for 1 of 2 reviewed (Resident # Findings included: Resident #6 was adm 6/16/21 with multiple Hypertension. The last MDS assess Resident #6 was a qu 8/11/21. There was n completed after 92 da MDS Nurse # 2 was i 2:30 PM. She verified MDS assessment wa She reviewed her cal- quarterly MDS was do completed on 11/11/2 missed.	24 sampled residents 6). hitted to the facility on diagnoses including ment completed for uarterly assessment dated no MDS assessment ays. hterviewed on 11/30/21 at d that Resident #6's last s completed on 8/11/21. endar and stated that a ue and should have been 11 but it was not, it was hg (DON) was interviewed A. The DON indicated that S assessments to be	F	538	DEFICIENT PRACTICE. A Quarterly Assessment was complete on November 30, 2021 and transmitted December 3, 2021 for Resident #6. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVIN THE POTENTIAL TO BE AFFECTED B THE SAME DEFICIENT PRACTICE. On December 1, 2021 both MDS Nurse were re-educated by an RAI Consultar RN on Chapter 2 of the RAI Manual on the timely completion and transmission Quarterly Assessments for all residents system audit was conducted on all Quarterly Assessments by the MDS Nur and verified by the RAI Consultant, RN December 2, 2021 and no additional deficient assessments were identified. ADDRESS WHAT MEASURES WILL E PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NO RECUR. A MDS Status Report Log was put into place that requires the MDS Nurse responsible for Quarterly Assessments daily check the MDS Status Report in American Health Tech (AHT) and Complete the Log indicating that the M Status Report was reviewed for all curr or upcoming Quarterly Assessments. O December 14, 2021 both MDS Nurses were educated by the Director of Nursi on the MDS Status Report Log and the	d on NG BY es at, a of s. A urse l on BE DT sto DS rent DN ng		

Event ID: KV8T11

Facility ID: 923187

If continuation sheet Page 5 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/06/2022 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345066	B. WING				C 1 02/2021
NAME OF PF	ROVIDER OR SUPPLIER	1	I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ALSTON E	BROOK				748 OLD SALISBURY ROAD		
				LI	EXINGTON, NC 27295		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 638	Continued From page	≥ 5	F	638	 process of checking the MDS Status Report in American Health Tech (AHT and completing the Log. INDICATE HOW THE FACILITY PLAN TO MONITOR ITS PERFORMANCE MAKE SURE THAT SOLUTIONS ARE SUSTAINED. The Director of Nursing or Designee v monitor MDS Status Report in Americ Health Tech (AHT) Electronic Medical Record (EMR) and the MDS Status Report Log to ensure all Quarterly Assessments are completed and transmitted as required. The monitorir will be conducted as follows: Monitor the MDS Status Report a MDS Status Report Log weekly for all residents for four (4) weeks; then Monitor the MDS Status Report a MDS Status Report Log bi-weekly for (4) weeks; then Monitor the MDS Status Report a MDS Status Report Log monthly until resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Committee. INCLUDE DATES WHEN CORRECTI ACTION WILL BE COMPLETED. 	NS TO E vill an ng nd four nd	
	7(02-99) Previous Versions Obs	solete Event ID: KV.			All re-education and new monitoring system will be put into place by Decer	nber	

Event ID: KV8T11

Facility ID: 923187

If continuation sheet Page 6 of 75

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/06/2023 M APPROVEI D. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345066	B. WING				C / 02/2021
NAME OF P	ROVIDER OR SUPPLIER	I		S	IREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON I	BROOK				748 OLD SALISBURY ROAD EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 638	Continued From page	9 6	F	638	30, 2021.		
F 641 SS=B	Accuracy of Assessm CFR(s): 483.20(g)	ients	F	641	50, 2021.		12/30/21
	resident's status. This REQUIREMENT by: Based on record rev facility failed to code (MDS) assessments Preadmission Screen (PASRR) (Resident # #6), prognosis (Resid (Resident #81) for 3 d reviewed. Findings included: 1a. Resident #6 was 6/16/21 with multiple depressive disorder. assessment dated 6/2 Resident #6 was not level II PASRR. A state form was revi Resident #6 was eval determined to have level MDS Nurse #2 was in 9:46 AM. She stated Nurse at the facility for stated that she didn't a level II PASRR. She records and verified t	admitted to the facility on diagnoses including major The admission MDS 28/21 indicated that event and indicated that luated on 4/22/21 and was			ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Resident #6, #26 and #81 assessmen modifications was transmitted on December 1, 2021. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED THE SAME DEFICIENT PRACTICE. Both MDS Nurses will be re-educated Chapter 3 of the RAI Manual on prope Coding and Accuracy of Assessments The MDS Consultant has conducted a review all MDS Assessments for the previous 90 days from December 2, 20 and found no additional coding inaccuracies. ADDRESS WHAT MEASURES WILL PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NO RECUR.	D t NG BY on t r 021 BE	

Facility ID: 923187

If continuation sheet Page 7 of 75

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/06/202 RM APPROVE IO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
		345066	B. WING		1	C 2/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
ALSTON I	PROOK			4748 OLD SALISBURY ROAD		
ALSTON	SKOOK			LEXINGTON, NC 27295		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From page	a 7	F 64	11		
1 041			F 04	+ 1		
	MDS to correct the in	uld complete a modification		The facility has implemented	l a system by	
		accardoy.		which all resident assessme	• •	
	The Director of Nursi	ng (DON) was interviewed		logged on the Alston Brook M		
		M. The DON indicated that		Assessment QA Log. This Lo	-	
		S assessments to be coded		the following information: Re		
	accurately.			Type assessment, PASRR L		
				Diagnosis, Prognosis, Medic		
	1h Desident #6 was	admitted to the facility on		Date Completed. In addition	•	
	6/16/21 with multiple	-		contains a QA Check Completed. The MDS N	•	
		arterly MDS assessment		all resident assessments on		
		ed that Resident #6 was not		must indicate that these item	-	
	coded as having seiz	ure disorder under the		present on the MDS assessr	ment. On	
	diagnoses.			December 14, 2021 both MD	OS Nurses	
				were educated by the Directed	•	
		s orders were reviewed.		on the Alston Brook MDS As		
		octor's order dated 7/19/21		Log and the process of loggi		
	(mgs) twice a day for	reat seizures) 500 milligrams		resident assessments on this indicating that these items w		
				on the MDS assessment.	ele pleselli	
	Review of the August	2021 Medication				
	-	ds (MARs) revealed that		INDICATE HOW THE FACIL	ITY PLANS	
		eived Keppra during the		TO MONITOR ITS PERFOR		
	assessment period.			MAKE SURE THAT SOLUTI	ONS ARE	
				SUSTAINED.		
		nterviewed on 12/2/21 at				
		that she had been an MDS		The Director of Nursing or Do review and monitor the Alsto		
		or 2 years. She reviewed s and verified that the		Assessment QA Log to ensu		
		r and was receiving Keppra		of all assessments as follows	•	
		ported that she missed to		1. Monitor the Alston Brook		
	-	er under the diagnoses. The		Assessment QA Log weekly		
		that she would complete a		residents for four (4) weeks;		
	modification MDS to	correct the inaccuracy.		2. Monitor the Alston Brook		
				Assessment QA Log bi-week	kly for four (4)	
		ng (DON) was interviewed		weeks; then		
		M. The DON indicated that		3. Monitor the Alston Brook		
	she expected the MD	S assessments to be coded		Assessment QA Log monthly	y until	

Facility ID: 923187

If continuation sheet Page 8 of 75

STATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			LETED
		345066	B. WING			C 02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE		02/2021
ALSTON	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(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 CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From page	e 8	F 64 ⁻	resolved by the Quality Assur	ance	
				Committee.		
2/1 de 9/1 ho: chi Re rev ad ME 9:4 Nu sta	2/1/17 with multiple d dementia. The annua 9/17/21 indicated tha	admitted to the facility on iagnoses including vascular II MDS assessment dated t Resident #26 was receiving the prognosis was not		On a quarterly basis the Direct Nursing will present the Qual Forms to the Quality Assuran Committee for monitoring and recommended changes.	ity Assurance ce	
	admission of 2017. MDS Nurse #2 was in 9:46 AM. She stated Nurse at the facility fo	dent was on hospice since nterviewed on 12/2/21 at that she had been an MDS or 2 years. MDS Nurse #2 know that she had to check		INCLUDE DATES WHEN CC ACTION WILL BE COMPLET All re-education and Alston B Assessment QA Log will be p by December 30, 2021.	ED. rook MDS	
	hospice services. Sh	e reported that she would on MDS to correct the				
	The Director of Nursing (DON) was interviewed on 12/2/21 at 1:08 PM. The DON indicated that she expected the MDS assessments to be coded accurately. 3) Resident #81 was admitted to the facility on 11/8/21 with diagnoses that included congestive heart failure (CHF) and chronic obstructive					
	pulmonary disease ((A review of the Medic (MAR) for Resident # revealed he received	COPD). cation Administration Record 81 from 11/9/21 to 11/15/21				

Facility ID: 923187

If continuation sheet Page 9 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 01/06/2022 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345066	B. WING			C 02/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	IREET ADDRESS, CITY, STATE, ZIP CODE	· ·=/	
ALSTON E	BOOK		47	748 OLD SALISBURY ROAD		
			L	EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	#81 was cognitively in antidepressant use. On 12/1/21 at 4:15 PM with MDS Nurse #1. November 2021 MAR should have been coo was an oversight.	9 (15/21 indicated Resident atact and was not coded for M, an interview occurred She reviewed the MDS and , confirming antidepressant ded for 7 days. She felt it n 12/2/21 at 1:07 PM, the	F 641			
F 689 SS=E	Director of Nursing inc new to the position and to include the antidep MDS assessment. SH expectation for the MI Free of Accident Haza CFR(s): 483.25(d)(1)(§483.25(d) Accidents. The facility must ensu §483.25(d)(1) The res as free of accident ha §483.25(d)(2)Each re supervision and assis accidents.	dicated MDS Nurse #1 was ad felt it was an oversight not ressant medication on the ne further stated it was her DS to be coded accurately. ards/Supervision/Devices 2)	F 689			12/30/21
	by: Based on record revi interview, the facility f investigate each fall to failed to put interventi prevent further falls for	ew, observation and staff ailed to thoroughly o determine root cause and		ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. On December 14, 2021 the Falls Interdisciplinary Team conducted a thorough review of dates of falls sited of		

Event ID: KV8T11

Facility ID: 923187

If continuation sheet Page 10 of 75

		MEDICAID SERVICES					NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· · ·	OATE SURVEY OMPLETED
		345066	B. WING				C
	ROVIDER OR SUPPLIER	343000	<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE		12/02/2021
NAME OF F	ROVIDER OR SUFFLIER						
ALSTON	BROOK				748 OLD SALISBURY ROAD EXINGTON, NC 27295		
(X4) ID	-	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	V	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETIO
PREFIX TAG	· · ·	LSC IDENTIFYING INFORMATION)	PREFIX TAG	^	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		DATE
F 689	Continued From page	> 10	F	689			
				009	the CMS 2567 on resident # 25 and #	67	
		admitted to the facility on			the CMS 2567 on resident # 25 and #		
	6/11/21 with multiple	U			and determined appropriate root caus	e of	
		e of the right fibula and tibia.			falls and reviewed all previous	41 1	
	The quarterly Minimu				interventions put in place and verified		
	assessment dated 9/				current appropriate interventions are i	IN	
		derate cognitive impairment dmission, reentry or prior			place to prevent future falls.		
	assessment with 2 or	more injury and one major			ADDRESS HOW THE FACILITY WIL	L	
	injury.				IDENTIFY OTHER RESIDENTS HAV	'ING	
					THE POTENTIAL TO BE AFFECTED	BY	
		blan was reviewed. One of ns was at risk for falls and			THE SAME DEFICIENT PRACTICE.		
		d 6/22/21. The approaches			The Falls Interdisciplinary Team		
		included physical therapy			conducted a thorough review of the la	ast	
		lying gait, remind to ask staff			30 days of falls which consisted of 18		
	. ,	pulation, keep walker within			residents and documented that each		
		r lift for transfer. There was			the 18 residents had a clearly determ		
		erventions since 6/22/21.			appropriate root cause of the fall and	incu	
					reviewed all previous interventions pu	ut in	
	The incident reports f	or Posidont #25 word			place and verified that current approp		
		for Resident #25 were					
	-	ts revealed that Resident			interventions are in place to prevent f	ulure	
		admission. The report did			falls.		
		e of the falls and what lace to prevent further falls.			ADDRESS WHAT MEASURES WILL	RE	
	The dates of the falls	•			PUT INTO PLACE OR SYSTEMIC	υC	
		WEIE.				т	
	8/7/21 at 2 DM "the				CHANGES MADE TO ENSURE THA		
	8/7/21 at 2 PM - "the	· · · ·			THE DEFICIENT PRACTICE WILL N		
		ent from bed to chair with a esident was lowered to the			RECUR.		
					A system was put into place where the	~	
	floor without injury."					C	
	8/20/21 at 11.51 AM	"the resident valled aut and			Falls Committee consisting of	C.	
		- "the resident yelled out and			Interdisciplinary Team members meet	5	
		esident on the floor with eresident was assisted to			immediately following the morning	hich	
					Stand-up meeting to review all falls w		
		uries and neuro check			occurred in the previous 24 hours. An		
		centimeter (cm)) to right			falls occurring on the weekend will be		
		e to right 3rd and 4th base of			reviewed on Mondays. The Falls		
	-	right eye and forehead			Committee will ensure that root cause	e of	
	were noted."				the fall is clearly documented and		

Facility ID: 923187

If continuation sheet Page 11 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:					LETED
							C
		345066	B. WING			12/	02/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				4	748 OLD SALISBURY ROAD		
ALSTON E	BROOK			L	EXINGTON, NC 27295		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREF	IX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	57112
F 689	Continued From neg	. 11		~~~			
F 009	Continued From page	3	- F	689			
					appropriate interventions are put into		
		NA informed Nurse that the			place. The Falls Committee will docum	ent	
		Iring transfer and was			all falls on the Alston Brook Falls		
		om a standup lift. Bruise and extremity and left toes,			Committee Review Form. On December 14, 2021 all Falls Interdisciplinary Tear		
		and pain to right shoulder			members were educated by the	115	
	and right knee were r				Administrator on the Systemic Change	9	
					put into place regarding the Falls	0	
	9/6/21 at 5:15 AM - "r	esident was heard from the			Committee and the Alston Brook Falls		
	nurse's station yelling	out "help, help". This			Committee Review Form. All Falls		
		n immediately. Resident			Interdisciplinary Team members were		
	was observed on floo	r on right side of bed in			required to receive the education prior	to	
	sitting position with ba	ack against the bed."			participating on the Falls Interdisciplina	iry	
					Team.		
		"NA reports preparing to					
		The resident was sitting on			INDICATE HOW THE FACILITY PLAN		
	side of bed while NA				TO MONITOR ITS PERFORMANCE T	0	
		elf. NA reports unable to			MAKE SURE THAT SOLUTIONS ARE		
		nce noted transferring self. ght knee and abrasion to left			SUSTAINED.		
	knee."	gni knee and abrasion to leit			The Administrator or his Designee will	ho	
	KIICC.				responsible to ensure that the Falls	be	
	Resident #25 was ob	served on 11/30/21 at 4:23			Committee is meeting daily as required	9	
		heelchair on the hallway.			with appropriate Interdisciplinary Team		
	-	ould bear weight on her right			Members to review all falls within the		
	leg and was still work				previous 24 hour and weekend falls and	Э	
					being reviewed on Mondays. The		
		ng (DON) was interviewed			Administrator or his Designee will		
		 The DON stated that 3 			complete a Falls Committee Review Fe	orm	
	administrative staff m				Log as follows:		
		evelopment Coordinator			1. Monitor the Alston Brook Falls		
	_ · · · ·	nd discuss the falls. They			Committee Review Forms once a week	<	
		reports and discuss what			for 4 weeks; then		
		place. The DON reported n they had discussed during			2. Monitor the Alston Brook Falls	Л	
		documented. The DON			Committee Review Form bi-weekly for weeks; then	4	
	-	e documentation that each			3. Monitor the Alston Brook Falls		
	-	ated and root cause was			Committee Review Form monthly until		
	identified. She was a				resolved by the Quality Assurance		

Facility ID: 923187

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		345066	B. WING		1:	2/02/2021
ALSTON I	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL		STREET ADDRESS, CITY, STATE, ZIP CO 4748 OLD SALISBURY ROAD LEXINGTON, NC 27295 PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTI	CORRECTION	(X5) COMPLETION
F 689	(EACH DEFICIENC REGULATORY OR I Continued From page documentation of wha put in place after each MDS Nurse #1 was ir 4:00 PM. She stated of falls during the mon Administrator. She re- involved in the weekly not clear of what inter the meeting. The SDC was intervie The SDC verified that and herself meet wee reports. She reported they reviewed the inc how to prevent furthe during the meeting, the identify the root cause discussed the interve not in writing. The Nurse Manager wat at 10:10 AM. The Nu- the incident reports. The	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	F 68	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE Y) ministrator will nee Forms to imittee for led changes. CORRECTIVE ETED. alls Committee	
	 place. She reported the discussed during the documented. 2) Resident #67 was 10/27/21 with diagnost fracture and Alzheime The admission Minim 	hat all the information meeting were not admitted to the facility on ses that included left clavicle er's disease. um Data Set (MDS) /3/21 indicated Resident				

Facility ID: 923187

If continuation sheet Page 13 of 75

	MENT OF HEALTH AN					FORM	D: 01/06/2022 M APPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345066	B. WING				C / 02/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON I	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	and transfers. She wa prior to admission. Resident #67's active 11/5/21) was reviewed risk of falls with a hist The problem area also resulting in injury. Th initiated on 11/5/21 in steadying gait, remind with ambulation, keep times and monitor for or wheelchair unassis revisions to the interve The incident reports for reviewed and reveale 11/21/21 at 3:45 AM. floor, sitting on her bo trying to get up becau the bed anymore. The alert staff. Bruising w left buttock and a sma left eyebrow. The rep cause of the fall or wh put into place to preve The Director of Nursir on 12/1/21 at 9:45 AM administrative staff me Manager and Staff De (SDC) met weekly to a reviewed incident rep members as needed a interventions were to	sistance for bed mobility as coded as having falls care plan (initiated on d with a problem area for ory of fall prior to admission. o listed a recent fall ne interventions that were cluded physical therapy for d to ask staff for assistance o walker within reach at all attempts to get out of bed sted. There had been no entions since 11/5/21. or Resident #67 were d a fall that occurred on She was observed on the ottom, and stated she was use she didn't want to be in e call light was not used to vas starting to form on the all skin tear was above her out did not include a root nat interventions had been ent further falls. ng (DON) was interviewed A and stated three embers (DON, Nurse evelopment Coordinator discuss falls. The members orts, spoke with staff and discussed what be put into place. The DON ne information that had been meeting was not	F	689			

Facility ID: 923187

If continuation sheet Page 14 of 75

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	D: 01/06/2022 MAPPROVED D. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
	345066	B. WING		_		C 02/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ALSTON BROOK			4748 OLD SALISBURY RO LEXINGTON, NC 27295			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 investigated, a root cau interventions had been further falls. MDS Nurse #1 was inte 4:00 PM and stated she during the morning mea Administrator. She rep with the weekly falls me clear of what intervention An interview occurred w 9:20 AM. She verified and herself met weekly reports. During those r incident reports and dis did not investigate nor falls. The SDC further s were discussed verball On 12/2/21 at 10:10 AM interviewed and verified met weekly to review in discussed what happer interventions to put into Manager added the infe not documented. F 692 SS=D CFR(s): 483.25(g) Assisted nu (Includes naso-gastric i 	sident #67's fall had been use identified or what put into place to prevent erviewed on 12/1/21 at e was made aware of falls eting with the orted she was not involved eeting and was not always ons were discussed. with the SDC on 12/2/21 at the DON, Unit Manager to discuss incident meetings they reviewed the scussed interventions but identify the root cause of stated the interventions y with nothing in writing. M, the Nurse Manager was d she, the DON and SDC ncident reports. They hed and what type of o place. The Nurse ormation discussed was tus Maintenance 3) thrition and hydration. and gastrostomy tubes, loscopic gastrostomy and pic jejunostomy, and on a resident's	F 68	39			12/30/21

Facility ID: 923187

If continuation sheet Page 15 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED	
STATEMENT (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345066	B. WING _				C 02/2021	
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•		
				47	48 OLD SALISBURY ROAD			
ALSTON E	BROOK			LI	EXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORREC REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREN D					(X5) COMPLETION DATE	
F 692	Continued From page	9 15	F 6	692				
	of nutritional status, s desirable body weigh balance, unless the re demonstrates that thi preferences indicate							
		s offered sufficient fluid intake to hydration and health;						
	there is a nutritional p provider orders a the	ed a therapeutic diet when problem and the health care rapeutic diet. is not met as evidenced						
	Based on record rev interview, the facility	iew, observation and staff failed to provide double ggs as ordered for 1 of 4 viewed for Nutrition			ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.)		
	1/29/20 with multiple dysphagia and vascu Minimum Data Set (N 10/14/21 indicated th moderate cognitive in extensive assistance	lar dementia. The quarterly IDS) assessment dated at Resident #54 has npairment and she needed with eating. The idicated that the resident's			Immediately upon being notified that improper portions were served to resid #54 additional portions were sent out to resident #54. In addition resident #54 dietary tray card for all meals was mark by a large clearly indicated "star" at the top of the dietary tray card to indicate double portions. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVIN THE POTENTIAL TO BE AFFECTED F	eed VG		
	the resident was grac weighed 160 lbs. on \$	54's weights revealed that lually losing weight. She 5/4/21, 155 lbs. on 8/23/21, and 148 lbs. on 11/15/21.			THE SAME DEFICIENT PRACTICE. On December 15, 2021 the facility Consultant Dietarian conducted a thorough audit to ensure all residents the			

Event ID: KV8T11

Facility ID: 923187

If continuation sheet Page 16 of 75

			() (a)			NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	TE SURVEY
			A. BUILDING	j		
		345066	B. WING			C
	ROVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, ZIP COD		2/02/2021
				4748 OLD SALISBURY ROAD	-	
ALSTON	BROOK			LEXINGTON, NC 27295		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION
F 692	Continued From page	2 16	F 69	2		
		octor's order dated 10/7/20	1 00	had orders for double portions	2 W/26	
		meat and eggs at all meals.		indicated on Dietary Tray Car		
		noar and oggo ar an modio.		residents with orders for doub		
	Resident #54 was ob	served during a lunch meal		were indicated on the Dietary		
		PM. NA #1 was observed to		and receiving double portions		
		resident. The diet listed on		all residents who are ordered		
		ee with nectar thick liquids"		portions; their Dietary Tray Ca		
		as to serve double portion of		marked by a large clearly indi		
m a		he tray was observed to have		at the top of the dietary tray c		
		uree vegetable, mashed		indicate double portions.		
		eat. NA #1 verified that the				
		gular portion and not double		ADDRESS WHAT MEASURE	S WILL BE	
		her stated that the resident		PUT INTO PLACE OR SYSTI		
	always eat 100% eve			CHANGES MADE TO ENSU		
		,		THE DEFICIENT PRACTICE		
	Resident #54 was ag	ain observed during a		RECUR.		
		/1/21 at 8:45 AM. NA #7 was				
	observed to serve an	d to feed the resident. The		On December 15, 2021 all Di	etary Staff	
	tray contained regula	r portion of puree sausage		was re-educated by the Cons	•	
	and puree eggs. NA	#7 verified the portion of the		Dietarian on serving of proper		
		regular and not double		and attention to detail on all D	•	
		that Resident #54 always		Cards to ensure proper portio	• •	
	eat 100% of her meal			are being served. In addition		
				educated on the new Double	Portion QA	
	The Dietary Manager	(DM) was interviewed on		Checklist and process. All Die	etary Tray	
	12/1/21 at 8:51 AM.	The DM reported that she		Cards for residents ordered d	ouble	
	was aware that Resid	lent #54 should have a		portions were marked by a lar	ge clearly	
		at and eggs for breakfast		indicated "star" at the top of th		
		meat for lunch and dinner		tray card to indicate double po		
	-	s. The DM stated that she		system was put into place on		
	did not have but 1 co			Serving Line to double check		
		ly the cook serves on the		that appropriate double portio	•	
	•	she did not have a cook		served prior to tray being sen		
		a dietary aide (DA) has		resident. A Double Portion QA		
		e. The DM added that she		was put into place that list all		
		read the dietary card and to		be served double portions each		
	pay attention to the in	struction "double portion."		Dietary Staff member working	-	
				line is responsible to physical	• •	
	The Registered Dietic	cian (RD) was interviewed	1	each tray for those residents	designated	1

Facility ID: 923187

If continuation sheet Page 17 of 75

	S FOR MEDICARE &			PLE CONSTRUCTION		NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	G		ATE SURVEY OMPLETED
			7.1 20122111			С
		345066	B. WING	B. WING		12/02/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CC	DE	
ALSTON B	BROOK			4748 OLD SALISBURY ROAD		
				LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 692	Continued From page	e 17	F 69	92		
		M. The RD verified that		for double portions and verif		
		aving weight loss and double vention to prevent further		contains double portions prid	•	
		ted that her expectation was		checks verified and initials the		
	for the resident to be	provided with the double		for each resident requiring d	ouble	
	portion as ordered.			portions.		
	The Dietary Aide (DA	A) was interviewed on 12/2/21		INDICATE HOW THE FACIL	ITY PLANS	
		ed that she had been		TO MONITOR ITS PERFOR		
		as DA for a year. She		MAKE SURE THAT SOLUT	IONS ARE	
		ped to cook and to serve on She indicated that she		SUSTAINED.		
	-	d the dietary card when		The Administrator or his Des	sianee will be	
		at an accident, she missed to		responsible to ensure that the		
	-	tion for Resident #54 on		Department Staff are utilizin	-	
	11/30/21 lunch and 1	2/1/21 breakfast.		Portion QA Checklist for eac observing random meals, ar	•	
				the QA Checklist. The Admin		
				Designee will complete and		
				Portion Monitoring Tool Form	n to ensure	
				compliance as follows: 1. Monitor the Double Por	tion OA	
				Checklist and observe the D		
				serving line randomly 3 mea	-	
				4 weeks; then		
				2. Monitor the Double Por Checklist and observe the D		
				serving line randomly 3 mea	-	
				bi-weekly for 4 weeks; then		
				3. Monitor the Double Por		
				Checklist and observe the D serving line randomly 4 mea	-	
				until resolved by the Quality		
				Committee.		
				On a quarterly basis the Dire		
				Nursing will present the Qua		
				Forms to the Quality Assura		
				Committee for monitoring ar	nd	

Event ID: KV8T11

Facility ID: 923187

If continuation sheet Page 18 of 75

	-	D HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IDI E	CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					LETED
							С
		345066	B. WING			12/	02/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON I	RPOOK			47	48 OLD SALISBURY ROAD		
ALSTON	SKOOK			LE	EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI> TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
1/10		,			DEFICIENCY)		
F 692	Continued From page	9 18	F 6	692	recommended changes.		
					· · · · · · · · · · · · · · · · · · ·		
					INCLUDE DATES WHEN CORRECTIV ACTION WILL BE COMPLETED.	/E	
					All re-education and new system will be put into place by December 30, 2021.	е	
F 756 SS=E		и, Report Irregular, Act On 2)(4)(5)	F 7	756			12/30/21
	must be reviewed at I licensed pharmacist. §483.45(c)(2) This re- of the resident's media §483.45(c)(4) The ph- irregularities to the at- facility's medical direc- and these reports mu (i) Irregularities includ drug that meets the c (d) of this section for a (ii) Any irregularities r during this review mu separate, written repo- attending physician a director and director of minimum, the residen and the irregularity th (iii) The attending phy resident's medical reo irregularity has been action has been taken be no change in the r	Ig regimen of each resident east once a month by a view must include a review cal chart. armacist must report any tending physician and the stor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist st be documented on a ort that is sent to the nd the facility's medical of nursing and lists, at a t's name, the relevant drug, e pharmacist identified. visician must document in the					

If continuation sheet Page 19 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/06/2022 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345066	B. WING _				C 02/2021
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
				474	48 OLD SALISBURY ROAD		
ALSTON E	ROOK			LE	XINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page the resident's medical		F 7	'56			
	drug regimen review t limited to, time frames the process and steps when he or she identi requires urgent action This REQUIREMENT by: Based on record revi Pharmacy Consultant Assistant and facility I Pharmacy Consultant facility's need to ident symptoms, to monitor need to monitor reside psychotropic medicati #67, # 81, #69, #34, # the Pharmacy Consul report drug irregularity discontinue a medicat #25). This was for 9 o medications were revi The findings included 1) Resident #12 was of facility on 8/27/21 with of 9/9/21. Her diagnos disease and major de The admission Minima assessment dated 9/3 had severe cognitive i no behavior issues. H poor appetite or overs	procedures for the monthly hat include, but are not a for the different steps in the pharmacist must take fies an irregularity that to protect the resident. is not met as evidenced ew and interviews with staff, facility Physician's Nurse Practitioner, the failed to identify the ify target behavioral those symptoms, and the ents for side effects of ons (Residents #12, #14, 17, and #6). In addition, tant failed to identify and v related to the failure to ion as ordered (Resident of 11 residents whose ewed.			ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. On December 14, 2021 new orders we entered for residents #12, #14, #67, #8 #69, #34, #17, #6, and #25 which inclu target behaviors/symptoms for each psychotropic medication including monitoring for potential adverse side effects. A discontinuation order for resident #25 was written and entered in AHT on December 1, 2021. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVIN THE POTENTIAL TO BE AFFECTED IN THE SAME DEFICIENT PRACTICE. On December 15, 2021 the Pharmaciss Consultant conducted a thorough audit of resident's orders and noted five order that needed to be discontinued. All not orders needing to be discontinued wer discontinued on December 15, 2021.	ere 31, ide nto NG BY t all ers ed	

Facility ID: 923187

If continuation sheet Page 20 of 75

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ С 345066 B. WING 12/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 756 Continued From page 20 F 756 days of an antidepressant. On December 15, 2021 the Pharmacist Consultant conducted an audit of Resident #12's physician orders included an psychotropic medications and of those order for Sertraline (an antidepressant) 50 residents who were audited found that milligrams by mouth daily. orders for psychotropic medications contained target behaviors/symptoms and Review of the Pharmacy Consultant medication required monitoring for potential adverse review notes for resident #12 from August 2021 to side effects as required. The Pharmacist November 2021 did not reflect the need for Consultant verified that the behavior type monitoring targeted behaviors or side effects. and adverse side are reflected on the electronic MAR. A review of Resident #12's nursing progress notes from 8/27/21 to 11/27/21 included ADDRESS WHAT MEASURES WILL BE behaviors such as wandering, pilfering, cursing, PUT INTO PLACE OR SYSTEMIC and hitting staff as well as crying and tearfulness. CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT Resident #12's Medication Administration RECUR. Records (MARs) from 9/1/21 to present indicated she received Sertraline as ordered. The MAR did On December 15, 2021 the Pharmacist not list any targeted behaviors or side effects for Consultant's were educated by the staff to monitor. Director of Nursing and Administrator on the need to report irregularities to the Director of Nursing or Medical Director On 11/30/21 at 1:32 PM, an interview occurred with the Director of Nursing (DON), who stated related to the failure to discontinue a she was aware of the need for identifying target medication as ordered. In addition on behaviors and monitoring for side effects of December 15, 2021 all nurses were psychotropic medications. She reported the educated by the Staff Development Nurse facility had two software programs with the on proper psychotropic medication orders capability to enter the monitoring of behaviors and entry into AHT to include diagnosis, target side effects on the MAR under a "special behaviors/symptoms for each requirement" tab, but apparently this was not psychotropic medication including being utilized by nursing. monitoring for potential adverse side effects. All psychotropic medication orders On 12/1/21 at 1:35 PM, an interview occurred will include target behaviors/symptoms for with Nurse #2 who was familiar with Resident #12 each psychotropic medication including and stated there were no specific behavior or side monitoring for potential adverse side effect monitoring for the use of the psychotropic effects. medications. INDICATE HOW THE FACILITY PLANS

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923187

If continuation sheet Page 21 of 75

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ С 345066 B. WING 12/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 756 Continued From page 21 F 756 An interview occurred with the Nurse Practitioner TO MONITOR ITS PERFORMANCE TO (NP) on 12/2/21 at 9:45 AM, and stated she was MAKE SURE THAT SOLUTIONS ARE aware target behaviors should be identified, SUSTAINED. monitored, and documented as well as side effect monitoring for any resident on psychotropic The Director of Nursing or Designee will medications. review all psychotropic medication orders entered to ensure accuracy including A telephone interview with the Pharmacy diagnosis, target behaviors/symptoms for Consultant was conducted on 12/2/21 at 11:45 each psychotropic medication including AM. She stated she expected the facility staff to monitoring for potential adverse side always monitor for adverse side effects and she effects. The Director of Nursing or looked for the evidence of identified target Designee will utilize the Alston Brook behaviors and side effect monitoring in the Psychotropic Medication Order Audit Log physician notes, nursing notes and psychological as follows: service notes if applicable. The Pharmacy 1. Monitor the psychotropic medication Consultant was unable explain why she did not orders 3 times a week for 4 weeks : then recommend the need to identify target behaviors 2. Monitor the psychotropic medication and side effect monitoring for Resident #12 in her orders 3 times bi-weekly for 4 weeks; then recommendations. Monitor the psychotropic medication 3. orders 4 times a month until resolved by the Quality Assurance Committee. 2) Resident #14 was originally admitted to the facility on 10/3/19 with a readmission date of On a quarterly basis the Director of 4/9/21. Her diagnoses included a history of a Nursing will present the Quality Assurance stroke, and major depressive disorder. Forms to the Quality Assurance Committee for monitoring and Resident #14's physician orders included an recommended changes. order dated 4/9/2, for Sertraline (an antidepressant) 25 milligrams by mouth daily. INCLUDE DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED. The annual Minimum Data Set (MDS) assessment dated 8/16/21 indicated Resident All re-education and new system will be #14 was cognitively intact and displayed no put into place by December 30, 2021. behavior issues. Her mood was coded as feeling tired or having little energy 7 to 11 days during the 14 day look back period. Resident #14 received 7 days of an antidepressant. Review of the Pharmacy Consultant medication

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 22 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/06/2022 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345066	B. WING					C 02/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
ALSTON	BROOK				.748 OLD SALISBURY ROAD .EXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 756	review notes for resid November 2021 did n monitoring targeted b A review of Resident to of refusing medication Resident #14's Medic Records (MARs) from she received Sertralin not list any targeted b nor side effects that n medication. On 11/30/21 at 1:32 F with the Director of Ne she was aware of the behaviors and monito psychotropic medicat facility had two softwa capability to enter the side effects on the MA requirement" tab, but being utilized by nursi On 12/1/21 at 1:35 Pf with Nurse #2 who wa and stated there were effect monitoring for ti medications. An interview occurred Assistant (PA) on 12/ she was aware target	 lent #14 from June 2021 to not reflect the need for ehaviors or side effects. #14's nursing progress 12/1/21 included a behavior is at times. eation Administration is poly 1/21 to present indicated the as ordered. The MAR did behaviors for staff to monitor may be displayed from the PM, an interview occurred ursing (DON), who stated need for identifying target oring for side effects of ions. She reported the are programs with the emonitoring of behaviors and AR under a "special apparently this was not ing. M, an interview occurred as familiar with Resident #14 eno specific behavior or side he use of the psychotropic With the facility Physician 1/21 at 2:45 PM, and stated is behaviors should be and documented as well as for any resident on 	F	756				

Facility ID: 923187

If continuation sheet Page 23 of 75

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345066	B. WING				C / 02/2021
NAME OF P	ROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 756	A telephone interview Consultant was condit AM. She stated she e always monitor for ad looked for the evidend behaviors and side eff physician notes, nurs service notes if applic Consultant was unable recommend the need and side effect monitor recommendations. 3) Resident #67 was 10/27/21 with diagnost depressive disorder, a Resident #67's physic order dated 10/27/21, antidepressant) 10 m evening. The admission Minim assessment dated 11 #67 had severe cognit displayed no behavio coded as feeling tired days during the 14 da Resident #67 receive antidepressant. Review of the Pharma review notes for resid to November 2021 dia monitoring targeted b A review of Resident notes from 10/27/21 t	with the Pharmacy ucted on 12/2/21 at 11:45 expected the facility staff to iverse side effects and she ce of identified target fect monitoring in the ing notes and psychological cable. The Pharmacy le explain why she did not to identify target behaviors oring for Resident #14 in her admitted to the facility on ses that included major and Alzheimer's disease. cian orders included an , for Citalopram (an illigrams by mouth every um Data Set (MDS) /3/21 indicated Resident itive impairment and r issues. Her mood was l or having little energy 2 to 6 ay look back period. d 7 days of an acy Consultant medication lent #67 from October 2021 d not reflect the need for ehaviors or side effects. #67's nursing progress	F	756			

Facility ID: 923187

If continuation sheet Page 24 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/06/2022 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		SURVEY PLETED
		345066	B. WING					C 02/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP COD	θE		
ALSTON E	3ROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B		(X5) COMPLETION DATE
F 756	Continued From page statements.	≥ 24	F	756				
	The MAR did not list a staff to monitor nor sid displayed from the me	n 10/27/21 to present d Citalopram as ordered. any targeted behaviors for de effects that may be edication.						
	with the Director of Nu she was aware of the behaviors and monito psychotropic medicati facility had two softwa capability to enter the side effects on the MA	monitoring of behaviors and AR under a "special apparently this was not						
	with Nurse #3 who wa and stated there were	M, an interview occurred as familiar with Resident #67 e no specific behavior or side he use of the psychotropic						
	Assistant (PA) on 12/ she was aware target	and documented as well as for any resident on						
	AM. She stated she e	ucted on 12/2/21 at 11:45 expected the facility staff to lverse side effects and she ce of identified target						

Facility ID: 923187

If continuation sheet Page 25 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 01/06/2022 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345066	B. WING			12	C 2/02/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON	BROOK				748 OLD SALISBURY ROAD EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 756	 physician notes, nurs service notes if applic Consultant was unable recommend the need and side effect monitor recommendations. 4) Resident #81 was 11/8/21 with diagnose heart failure (CHF) ar pulmonary disease (CResident #81's physic dated 11/8/21 for Bup 100 milligrams (mg) be Aripiprazole (an antip twice a day. The admission Minim assessment dated 11 #81 was cognitively in or behavior issues. Review of the Pharmar review notes for resid 2021 did not reflect the targeted behaviors or A review of Resident #81's Medic Records (MARs) from indicated he received as ordered. The MAR 	ing notes and psychological cable. The Pharmacy le explain why she did not it to identify target behaviors oring for Resident #67 in her admitted to the facility on es that included congestive nd chronic obstructive COPD). cian orders included orders oropion (an antidepressant) by mouth every morning and osychotic) 5mg by mouth num Data Set (MDS) /15/21 indicated Resident ntact and displayed no mood acy Consultant medication lent #81 from November ne need for monitoring side effects. #81's nursing progress o 12/1/21 included no mood cation Administration n 11/8/21 to present I Bupropion and Aripiprazole R did not list any targeted monitor nor side effects that	F	756			

Facility ID: 923187

If continuation sheet Page 26 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/06/2022 APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345066	B. WING				C 12/02/2021		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
ALSTON E	BROOK			4	748 OLD SALISBURY ROAD				
ALOTONI	SKOOK			L	EXINGTON, NC 27295				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)				(X5) COMPLETION DATE	
F 756	6 Continued From page 26		F	756					
	with the Director of Ne she was aware of the behaviors and monito psychotropic medicati facility had two softwa capability to enter the side effects on the MA requirement" tab, but being utilized by nursi On 12/1/21 at 1:50 PP with Nurse #3 who wa and stated there were effect monitoring for the medications. An interview occurred Assistant (PA) on 12/ she was aware target identified, monitored, side effect monitoring psychotropic medication At telephone interview Consultant was condu AM. She stated she e always monitor for ad looked for the evidend behaviors and side eff physician notes, nursi service notes if applic Consultant was unabli recommend the need	monitoring of behaviors and AR under a "special apparently this was not ing. M, an interview occurred as familiar with Resident #81 e no specific behavior or side he use of the psychotropic I with the facility Physician 1/21 at 2:45 PM, and stated behaviors should be and documented as well as for any resident on ions. with the Pharmacy ucted on 12/2/21 at 11:45 xpected the facility staff to verse side effects and she ce of identified target fect monitoring in the ing notes and psychological							
	5. Resident #69 admi	tted on 9/15/20 with a							

Facility ID: 923187

If continuation sheet Page 27 of 75

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	APPROVED		
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	345066	B. WING _			ECTION (X5) COMPLETED C 12/02/2021			
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
ALSTON BROOK				748 OLD SALISBURY ROAD EXINGTON, NC 27295				
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	E ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE			
disturbance. The quarterly Minimum 11/1/21 indicated Resid cognitive impairments behaviors during the 7 the assessment. He wa taking an antipsychotic Review of Resident #6 Physician orders includ 25 milligrams (mg) eve every night at bedtime. Resident #69's monthly medication review note 6/16/21-no recomme 7/21/21-be sure speci identified and documer 8/18/21- be sure speci identified and documer 9/21/21-no recomme 10/19/21-no recomme Seroquel 11/16/21-no recomm Seroquel 11/16/21-no recomm Review of Resident #6 administration records November 2021 indica Seroquel as ordered. T identified target behavi monitoring for side effer Review of Resident #6 6/1/21 to 11/30/21 inclu	A Data Set (MDS) dated dent #69 had severe and he exhibited no day look back period for as coded as taking as c on a routine basis. 9's November 2021 ded the following: Seroquel ery morning and 25 mg y Consultant Pharmacist es read the following: endations cific target behaviors are need for Seroquel cific target behaviors are need for Seroquel endations eendation regarding endations 9's medication from June 2021 to ted he received his There was no evidence of iors and no evidence of ects. 9's nursing notes from uded the following male staff, wandering into	F	756					

Facility ID: 923187

If continuation sheet Page 28 of 75

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/06/2022 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345066	B. WING				C 12/02/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ALSTON	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 756	roommates urinary carelease. Observation on 11/29 #69 was in his room s was cooperative and agitation, wandering of An interview with the was conducted on 11, stated she was aware target behaviors and in psychotropic medicati facility had two softwas capability to enter the side effects on the M/ requirement" tab, but being utilized by nursi An interview was com 12/1/21 at 8:30 AM. S exhibited wandering to behaviors and inappro- staff. An interview was com Assistant (NA) #9 on stated she was very fi She stated the only b was him wandering in for some reason, he w door he saw open. An interview was com- assistant (PA) on 12/7 she depended on the behaviors were exhib prescribed a psychotr	atheter bag and refusing to //21 at 1:18 PM, Resident sitting in his wheelchair. He did not exhibit any signs of or aggression. Director of Nursing (DON) /30/21 at 1:32 PM. She e of the need for identifying monitoring for side effects of ions. She reported the are programs with the monitoring of behaviors and AR under a "special apparently this was not ing. ducted with Nurse #4 on She stated Resident #69 behaviors, exit seeking opriately touched the female ducted with Nursing 12/1/21 at 9:00 AM. She amiliar with Resident #69. ehaviors she had observed to other resident rooms and went around closing any ducted with the physician's 1/21 at 2:45 PM. She stated nurses to tell her what	F	756				

Facility ID: 923187

If continuation sheet Page 29 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345066	B. WING			COMPLETED C 12/02/2021			
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	-			
ALSTON I	ALSTON BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	COMPLETION		
F 756	should be identified, of and there should be s resident prescribed part A telephone interview Pharmacist was cond AM. She stated she m concerns in July 2021 she thought the recorn completed. The Const when doing her month review the MARs to e adverse side effects w stated she referred to physician progress no behaviors, effectivened the antipsychotic med Resident #69. An interview with the 12:25 PM. He stated facility was having an medications. 6. Resident #34 was anxiety and depression Her quarterly Minimum 9/30/21 indicated she she exhibited no behave period for the assessing coded for taking antia medications. Review of Resident # Physician orders inclu 0.25 milligrams (mg)	documented and monitored side effect monitoring for any sychotropic medications. If with the Consultant ucted on 12/2/21 at 11:45 ecommended the identified 1 and August 2021 because nmendation had been ultant Pharmacist stated hly review, it was difficult to nsure target behaviors and were monitored daily. She nursing notes and otes to monitor for specific ess and for side effects of dications prescribed for Administrator on 12/2/21 at he was not aware that the y issues with psychotropic admitted 4/12/18 with of on. Im Data Set (MDS) dated was cognitively intact and aviors in the 7 day look back ment. Resident #34 was inxiety and antidepressant	F	756					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345066	B. WING				C 02/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>		
	BDOOK			4	748 OLD SALISBURY ROAD			
ALSTON	BRUUK			L	EXINGTON, NC 27295			
(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 756	Continued From page	e 30	F	756				
	medication review no 6/16/21-no recomme of Wellbutrin 7/21/21-no recomme and Wellbutrin 9/21/21-no recomme and Wellbutrin 9/21/21-no recomme and Wellbutrin 10/19/21-recommend of a Wellbutrin order of 11/16/21-no recomm and Wellbutrin Review of Resident # administration records November 2021 indic Xanax and Wellbutrin evidence of identified evidence of identified evidence of monitorin Review of Resident # 6/1/21 to 11/30/21 indic behaviors: no docume 2021, August 2021, S October 2021. Nursin 11/15/21, 11/19/21 ar tearful. An interview with the was conducted on 11 stated she was aware target behaviors and psychotropic medicat facility had two software	and the second s						

Facility ID: 923187

If continuation sheet Page 31 of 75

		D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/06/2022 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345066	B. WING					02/2021
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ALSTON E	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295			
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BI		(X5) COMPLETION DATE
F 756	being utilized by nursi An interview with the conducted on 12/1/21 obtained her informat the staff and her famil expected the Consult the need for target be for side effects. The I different software prop helpful, but it was too in two different software chart. An observation and in 12/1/21 at 10:40 AM. room lying in bed. She herself lately and note An interview was com 12/1/21 at 3:55 PM. Shas been accusing ot things and clothing. N discovered that Resid clothes in the trash ar She stated she had no being tearful. An interview was com 12/2/21 at 9:05 AM. So observed any agitatio noted an increase in F residents messing wit A telephone interview Pharmacist was cond	apparently this was not ing. nurse practitioner (NP) was at 9:44 AM. She stated she ion about Resident #34 from y. The NP stated she ant Pharmacist to identify haviors and the monitoring NP stated if the facility had a gram, it was would be much for the nurses to work are programs and the hard terview was conducted on Resident #34 was in her e stated she had not felt like ed more confusion. ducted with NA #5 on She stated Resident #34 her residents of taking her IA #5 stated it was lent #34 was throwing her nd staff had to go retrieve it. ot observed Resident #34 ducted with Nurse #5 on she stated she had not n or crying but she had Resident #34 accusing other h her things. with the Consultant ucted on 12/2/21 at 11:45	F	756				
	AM. The Consultant	Pharmacist stated when iew, it was difficult to review						

Facility ID: 923187

If continuation sheet Page 32 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/06/2022 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345066	B. WING				C / 02/2021	
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE			
ALSTON E	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 756	the MARs to ensure ta side effects were mon referred to nursing no notes to monitor for sp effectiveness and for psychotropic medicati #34. An interview with the 12:25 PM. He stated I facility was having any medications. 7. Resident #17 was a diagnosis of depression His quarterly Minimum 9/1/21 indicated he way exhibited no behavior period for the assess coded for taking antid Review of Resident # Physician orders inclu 60 milligrams (mg) on Resident #17's month	arget behaviors and adverse hitored daily. She stated she ones and physician progress pecific behaviors, side effects of the ions prescribed for Resident Administrator on 12/2/21 at he was not aware that the y issues with psychotropic admitted 10/20/20 with a on. In Data Set (MDS) dated as cognitively intact and he is in the 7 day look back ment. Resident #17 was lepressant medications. It7's November 2021 uded the following: Cymbalta nee daily. Inly Consultant Pharmacist tes read the following: endations regarding endations regarding endations regarding endations regarding endation regarding	F	756				

Facility ID: 923187

If continuation sheet Page 33 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/06/2022 APPROVED D. 0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED				
		345066	B. WING				C 12/02/2021				
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	νE					
ALSTON E	BROOK		4748 OLD SALISBURY ROAD								
ALOTONI	SKOOK			I	LEXINGTON, NC 27295						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)				(X5) COMPLETION DATE			
F 756	Review of Resident # administration records November 2021 indic Cymbalta as ordered. identified target behav monitoring for side eff Review of Resident # 6/1/21 to 11/30/21 did documentation regard An observation and ir was conducted on 11, in bed playing on a la complimentary of the no concerns. An interview with the was conducted on 11, stated she was award target behaviors and psychotropic medicat facility had two softwa capability to enter the side effects on the MA requirement" tab, but being utilized by nursi An interview was com assistant (PA) on 12/ ⁷ she depended on the behaviors were exhib prescribed a psychotr stated she was award should be identified, of and there should be so resident prescribed psychot	17's medication a from June 2021 to ated he received his There was no evidence of viors and no evidence of ects. 17's nursing notes from not include any ling any behaviors. Aterview with Resident #17 (30/21 at 9:41 AM. He lying ptop. Resident #17 was facility and staff. He voiced Director of Nursing (DON) (30/21 at 1:32 PM. She of the need for identifying monitoring for side effects of ions. She reported the are programs with the monitoring of behaviors and AR under a "special apparently this was not ing. ducted with the physician's 1/21 at 2:45 PM. She stated nurses to tell her what ited for any resident opic medications. She that target behaviors locumented and monitored ide effect monitoring for any sychotropic medications.	F	756							
	An interview was con	ducted with NA #10 on									

Facility ID: 923187

If continuation sheet Page 34 of 75

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345066	B. WING _				C 02/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
ALSTON	BROOK				748 OLD SALISBURY ROAD EXINGTON, NC 27295			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 756	 12/2/21 at 9:10 AM. S inappropriate with the not observed any cryit loss of appetite. An interview was con 12/2/21 at 9:15 AM. S not exhibit any evider changes in his appetit refused care but agree A telephone interview Pharmacist was cond AM. The Consultant doing her monthly rev the MARs to ensure t side effects were mor referred to nursing no notes to monitor for s effectiveness and for psychotropic medicat #17. An interview with the 12:25 PM. He stated facility was having an medications. 8. Resident #25 was a 6/11/21 with multiple disorder. The quarterly Minimu assessment dated 9/7 Resident #25 has a d for Calcium Carbonat tablet by mouth daily 	She stated Resident #17 was a female staff but she had ng, sadness, agitation or ducted with Nurse #1 on She stated Resident #17 did nee of sadness, crying or te but he occasionally ed with reapproach. Twith the Consultant ucted on 12/2/21 at 11:45 Pharmacist stated when view, it was difficult to review arget behaviors and adverse hitored daily. She stated she tes and physician progress pecific behaviors, side effects of the ions prescribed for Resident Administrator on 12/2/21 at he was not aware that the y issues with psychotropic admitted to the facility on diagnoses including anxiety m Data Set (MDS) 17/21 indicated that derate cognitive impairment. octor's order dated 7/12/21 e 500 milligrams (mgs) 1	F	756				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/06/2022 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345066	B. WING			C 12/02/2021		
NAME OF P	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STAT	FE, ZIP CODE			
ALSTON	BROOK			748 OLD SALISBURY ROAD EXINGTON, NC 27295	0			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE	
F 756	(MARs) from July thro revealed that Calcium discontinued after 30 #25 continued to rece as of 12/1/21. Review of the monthly (DRR) was conducted Consultant has condu 9/21/21, 10/19/21 and not address the irregu discontinue the Calciu Nurse #1, assigned to interviewed on 12/1/2 reviewed the doctor's Calcium Carbonate w should have been dis was not. She reporte transcribed the order date and therefore it w #1 stated that she wo error. The PA was interview The PA reported that medication error on R Calcium Carbonate. expected the nurses t unnecessary medicat ordered to discontinue today. The Pharmacy Consu 12/2/21 at 9:35 AM. S verified that Calcium 0 30 days on 7/12/21 for reviewed the monthly	bugh December 2021 a Carbonate was not days as ordered. Resident ive the Calcium Carbonate y drug regimen review d. The Pharmacy acted the DRR on 8/18/21, d 11/16/21. The reviews did ularity regarding the failure to um Carbonate as ordered. b Resident #25, was 1 at 12:15 PM. She orders and verified that vas ordered for 30 days and continued on 8/12/21 but it d that the Nurse who to MAR did not put a stop was not discontinued. Nurse uld inform the doctor of the eed on 12/1/21 at 3:40 PM. she was informed of the tesident #25 regarding the She stated that she to follow the order to prevent ion. The PA added that she te the Calcium Carbonate ultant was interviewed on She reviewed the orders and Carbonate was ordered for	F 756					

Facility ID: 923187

If continuation sheet Page 36 of 75

	-	ID HUMAN SERVICES				FORM	01/06/2022 APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	LETED
		345066	B. WING			12/0	C 02/2021
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ALSTON	BROOK			4748 OLD SALISBURY RC LEXINGTON, NC 2729			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	and addressed with th was missed. The Director of Nursir on 12/2/21 at 1:08 PM	he DON nor the physician, it ng (DON) was interviewed A. She stated that she ncy Consultant to identify and	F 75	6			
	6/16/21 with multiple depression and anxie Data Set (MDS) asse indicated that Resider cognitive impairment antianxiety and antide days during the asses Resident #6 has doct	ety. The quarterly Minimum essment dated 8/11/21 nt #6 has moderate and has received an epressant medications for 7					
	on 6/16/21 and Klono bedtime for anxiety of Review of Resident # revealed no document target behaviors and psychotropic medicat Review of the monthly (DRR) for Resident # Pharmacy Consultant Resident #6 on 7/21/2 10/19/21 and 11/16/2 address the need to r the target behaviors.	 ppin 0.5 mgs by mouth at n 8/1/21. 6's medical records nation of monitoring for the the side effects of the ions. y drug regimen reviews 6 was conducted. The thas completed the DRR for 					

Facility ID: 923187

If continuation sheet Page 37 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/06/2022 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345066	B. WING				C 02/2021
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON E	BROOK				748 OLD SALISBURY ROAD EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	side effects of psycho reported that the facil programs and has the monitoring of behavio Medication Administra the special requirement we nursing. Interview with the Phy conducted on 12/1/21 that she was aware the be identified, monitore there should be side of residents on psychotron Interview with the Pha conducted on 12/2/21 Pharmacy Consultant the staff to always more effects of psychotropi reported that she look and the side effects in progress notes, nursi notes if any. She add recommended the ne in July and August 20 explain why she did in identify target behavio monitoring for Reside recommendations. Drug Regimen is Free	ware of the need for aviors and monitoring for btropic medications. She ity has two software e capability to enter the brs and side effects on the ation Record (MAR) under ents, but apparently this vas not being used by ysician Assistant (PA) was at 2:45 PM. The PA stated hat target behaviors should ed, and documented and effects monitoring for any ropic medications. armacy Consultant was at 11:45 AM. The t stated that she expected ponitor for adverse side c medications. She ked for the target behaviors honitoring in the physician ing notes and psychiatric ed that she had ed to monitor the behaviors bot recommend the need to pris and side effect ent #6 in her e from Unnecessary Drugs		756			12/30/21
	§483.45(d) Unnecess Each resident's drug	ary Drugs-General. regimen must be free from					

Facility ID: 923187

If continuation sheet Page 38 of 75

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/06/2022 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			COM	E SURVEY PLETED
		345066	B. WING				C / 02/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON E	BROOK				748 OLD SALISBURY ROAD		
					EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 757	Continued From page	- 38	Í F	757			
		An unnecessary drug is any		101			
	§483.45(d)(1) In excessive dose (including duplicate drug therapy); or						
	§483.45(d)(2) For exe	cessive duration; or					
	§483.45(d)(3) Withou	it adequate monitoring; or					
	§483.45(d)(4) Withou use; or	It adequate indications for its					
	§483.45(d)(5) In the p consequences which reduced or discontinu	indicate the dose should be					
		mbinations of the reasons (d)(1) through (5) of this					
	This REQUIREMENT by:	「 is not met as evidenced					
	(PA) and staff intervie discontinue a medica	iew and Physician Assistant ew, the facility failed to tion as ordered for 1 of 10 viewed for unnecessary ht #25).			ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHEI FOR THOSE RESIDENTS FOUND T HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.		
	Findings included:				The medication is question on Reside #25 was discontinued on December		
	6/11/21 with multiple disorder. The quarte assessment dated 9/ Resident #25 has mo	mitted to the facility on diagnoses including anxiety rly Minimum Data Set (MDS) 17/21 indicated that oderate cognitive impairment. doctor's order dated 7/12/21			2021. ADDRESS HOW THE FACILITY WIL IDENTIFY OTHER RESIDENTS HAV THE POTENTIAL TO BE AFFECTED THE SAME DEFICIENT PRACTICE.	L ′ING	
		te 500 milligrams (mgs) 1			On December 15, 2021 the Pharmac Consultant conducted a thorough au		

Facility ID: 923187

If continuation sheet Page 39 of 75

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345066 B. WING 12/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 757 Continued From page 39 F 757 of resident's orders and noted five orders Review of the Medication Administration Records that needed to be discontinued. All five (MARs) from July through December 2021 noted orders needing to be discontinued revealed that Calcium Carbonate was not were discontinued on December 15, discontinued after 30 days as ordered. Resident 2021. #25 continued to receive the Calcium Carbonate as of 12/1/21. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC Nurse #1, assigned to Resident #25, was CHANGES MADE TO ENSURE THAT interviewed on 12/1/21 at 12:15 PM. She THE DEFICIENT PRACTICE WILL NOT reviewed the doctor's orders and verified that RECUR Calcium Carbonate was ordered for 30 days and should have been discontinued on 8/12/21 but it On December 15, 2021 all nurses were was not. She reported that the Nurse who be re-educated by the Staff Development transcribed the order to MAR did not put a stop Nurse on proper order entry pertaining to date and therefore it was not discontinued. Nurse order stop date entry which results in the #1 stated that she would inform the doctor of the discontinuation of the medication. error. Physician orders will be screened on a daily basis by the First Shift Nurse The PA was interviewed on 12/1/21 at 3:40 PM. Manager and the Staff Development The PA reported that she was informed of the Nurse to determine orders requiring an medication error on Resident #25 regarding the order stop date and orders will be logged on the Order Entry Medication Stop Date Calcium Carbonate. She stated that she expected the nurses to follow the order to prevent Checklist and those will be verified for unnecessary medication. The PA added that she proper entry in AHT and verification and/or ordered to discontinue the Calcium Carbonate correction will be noted on Order Entry today. Medication Stop Date Checklist and followed up with entering nurse as The Director of Nursing (DON) was interviewed needed. On December 15, 2021 the First on 12/2/21 at 1:08 PM. She stated that she Shift Nurse Manager and the Staff expected the nurses to follow the doctor's order. Development Nurse were educated by the Director of Nursing on the Order Entry Medication Stop Date Checklist and Physician order stop date order screening process. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KV8T11

Facility ID: 923187

If continuation sheet Page 40 of 75

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/06/2022 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345066	B. WING				C / 02/2021
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ALSTON	BROOK			47	748 OLD SALISBURY ROAD		
				L	EXINGTON, NC 27295		1
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	Continued From page	2 40	F	757	SUSTAINED.		
F 758 SS=E	CFR(s): 483.45(c)(3)(§483.45(e) Psychotro §483.45(c)(3) A psych affects brain activities processes and behav		F	758	 The Director of Nursing or Designee w monitor the Order Entry Medication Ste Date Checklist as follows: Monitor the Order Entry Medication Stop Date Checklist weekly 3 times a week for 4 weeks ; then Monitor the Order Entry Medication Stop Date Checklist bi-weekly 3 times week for 4 weeks; then Monitor the Order Entry Medication Stop Date Checklist 4 times a month use resolved by the Quality Assurance Committee. On a quarterly basis the Director of Nursing will present the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTINACTION WILL BE COMPLETED. All re-education and new system will b put into place by December 30, 2021. 	op on a on on intil ance	12/30/21

Facility ID: 923187

If continuation sheet Page 41 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/06/2022 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345066	B. WING		_		C 02/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ALSTON E	BROOK			4748 OLD SALISBURY RO LEXINGTON, NC 27295			
(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 758	resident, the facility m §483.45(e)(1) Reside psychotropic drugs ar unless the medication specific condition as of in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventio contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs pu unless that medication diagnosed specific co in the clinical record; a §483.45(e)(4) PRN or are limited to 14 days §483.45(e)(5), if the a prescribing practitione appropriate for the PF	ensive assessment of a nust ensure that nts who have not used e not given these drugs a is necessary to treat a diagnosed and documented nts who use psychotropic dose reductions, and ns, unless clinically effort to discontinue these nts do not receive ursuant to a PRN order n is necessary to treat a ndition that is documented and rders for psychotropic drugs . Except as provided in ttending physician or	F 758				
	rationale in the reside indicate the duration f §483.45(e)(5) PRN or drugs are limited to 14 renewed unless the a	nt's medical record and for the PRN order. rders for anti-psychotic 4 days and cannot be ttending physician or er evaluates the resident for					

Facility ID: 923187

If continuation sheet Page 42 of 75

CENTER STATEMENT (AND PLAN OF NAME OF PL ALSTON E	S FOR MEDICARE & I PF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER BROOK	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345066	A. BUILDI B. WING	ING	TREET ADDRESS, CITY, STATE, ZIP CODE 748 OLD SALISBURY ROAD EXINGTON, NC 27295 PROVIDER'S PLAN OF CORRECTION	FORM OMB NC (X3) DATE COMP	LETED C 02/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	This REQUIREMENT by: Based on record revi Pharmacy Consultant Assistant and facility I facility failed to identif behavioral symptoms monitor residents for medications (Resident #34, #17, #28 and #6 residents whose med The findings included 1) Resident #12 was of facility on 8/27/21 with of 9/9/21. Her diagnos disease and major de Resident #12's physic order for Sertraline (a milligrams by mouth of The admission Minim assessment dated 9/3 had severe cognitive no behaviors. Her mo appetite or overeating day look back period. days of an antidepress A review of Resident a date of 9/7/21, revealed of an antidepressant in depression. The inter- patterns of target beh side effects, documer	is not met as evidenced ew and interviews with staff, facility Physician's Nurse Practitioner, the y the need to monitor target , as well as the need to side effects of psychotropic ts #12, #14, #67, # 81, #69,). This was for 9 of 11 ications were reviewed. : originally admitted to the n a recent readmission date ses included Alzheimer's pressive disorder. tan orders included an n antidepressant) 50 laily. um Data Set (MDS) 8/21 indicated Resident #12 impairment and displayed od was coded with poor 12 to 6 days during the 14 Resident #12 received 7	F	758	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. On December 14, 2021 new orders entered for residents #12, #14, #67, #8 #69, #34, #17, #6, and #28 which inclu- target behaviors/symptoms for each psychotropic medication including monitoring for potential adverse side effects. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVI THE POTENTIAL TO BE AFFECTED THE SAME DEFICIENT PRACTICE. On December 15, 2021 the Pharmacis Consultant conducted an audit of psychotropic medications and of those residents who were audited found that orders for psychotropic medications contained target behaviors/symptoms required monitoring for potential adver side effects as required. The Pharmace Consultant verified that the behavior ty and adverse side are reflected on the electronic MAR. ADDRESS WHAT MEASURES WILL IP PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NO RECUR.	B1, ide NG BY it and se ist rpe BE	

Facility ID: 923187

If continuation sheet Page 43 of 75

		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION		TE SURVEY MPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	IG		
						С
		345066	B. WING			2/02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ALSTON I	RPOOK			4748 OLD SALISBURY ROAD		
ALGIONI	SKOOK			LEXINGTON, NC 27295		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIOI DATE
F 758	Continued From page	e 43	F 7	58		
		acy Consultant medication		On December 15, 2021 al	nurses were	
		lent #12 from August 2021 to		educated by the Staff Dev		
		not reflect the need for		on proper psychotropic me	•	
	monitoring targeted b	ehaviors or side effects.		entry into AHT to include of		
	monitoring targeted behaviors or side effects.			behaviors/symptoms for e	ach	
	A review of Resident	#12's nursing progress		psychotropic medication ir	cluding	
	notes from 8/27/21 to	o 11/27/21 included		monitoring for potential ad	verse side	
e F		andering, pilfering, cursing,		effects. All psychotropic m		
	and hitting staff as we	ell as crying and tearfulness.		will include target behavio		
				each psychotropic medica	-	
	Resident #12's Medic			monitoring for potential ad	verse side	
		n 9/1/21 to present indicated		effects.		
		ne as ordered. There was				
		fied target behaviors or		INDICATE HOW THE FAC		
	monitoring for side ef	Tects.		TO MONITOR ITS PERFO		
	An interview was son	ducted with the Director of			HUNS ARE	
		ducted with the Director of		SUSTAINED.		
		/30/21 at 1:32 PM. She s target behaviors and side		The Director of Nursing or	Docianoo will	
		documented if observed in		review all psychotropic me	•	
	-	d on the nursing acute		entered to ensure accurac		
	-	ot part of the medical record.		diagnosis, target behavior		
		cility had the capability to		each psychotropic medica		
	-	ors and side effects when		monitoring for potential ad	-	
		a psychotropic medication		effects. The Director of Nu		
	-	edical record (EMR) under		Designee will utilize the Al	-	
	the "special requirem			Psychotropic Medication (
	completed when the	medication was entered in		as follows:	-	
	the EMR, it would ap	pear on the resident's MAR,		1. Monitor the psychotro	pic medication	
		er this was not being done or		orders 3 times a week for		
		grams the facility used did		2. Monitor the psychotro		
		h each other. The DON		orders 3 times bi-weekly for		
		reviewed all the psychotropic		3. Monitor the psychotro		
		with the Nurse Manager (NM)		orders 4 times a month un	-	
		e need for identifying target		the Quality Assurance Cor	nmittee.	
		pring for side effects of			· · ·	
	psychotropic medicat	tions.		On a quarterly basis the D		
	0= 11/00/04 + 0.45			Nursing will present the Q		
	On 11/30/21 at 3:15 F	rivi, an interview was		Forms to the Quality Assu	ance	

Event ID: KV8T11

Facility ID: 923187

If continuation sheet Page 44 of 75

	S FOR MEDICARE &						NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
							С
		345066	B. WING				12/02/2021
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON E	BROOK				48 OLD SALISBURY ROAD EXINGTON, NC 27295		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 758	Continued From pag	e 44	F 75	58			
		lurse Manager (NM), who			Committee for monitoring and		
		the psychotropic medications			recommended changes.		
	and worked with the	physician regarding the need			-		
		uctions, but target behaviors			INCLUDE DATES WHEN CORRECT	TIVE	
		oring was not discussed, as documenting these areas if			ACTION WILL BE COMPLETED.		
	observed. The NM st			All re-education and new system will	be		
	psychotropics require			put into place by December 30, 202			
		ot routinely monitor for side					
		would contact the physician					
		ed in the resident. The NM system for charting had a tab					
		rements" in which side effects					
		could be identified but the					
		ns did not communicate with					
	each other.						
	On 11/30/21 at 3:30 l	PM, Resident #12 was					
	observed sitting up ir						
	common area talking	with another resident.					
	On 12/1/21 at 1:35 P	M, an interview occurred					
		stated Resident #12 became					
	, ,	other residents, would curse,					
		Nurse #2 stated there was or or side effect monitored					
		e Physician orders, however					
		as told of any behaviors, it					
		d in the nursing progress					
	notes and reported to	o the physician as needed.					
	An interview was cor	mpleted with Nurse					
		12/2/21 at 9:45 AM, who					
	explained she relied	on the nursing staff to report					
		displaying any behaviors or					
		tidepressant medication.					
	She further stated sh behaviors should be	identified, documented, and					

If continuation sheet Page 45 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/06/2022 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í				(X3) DATE COMP	SURVEY LETED
		345066	B. WING					C 02/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STA	TE, ZIP CODE	-	
ALSTON	BROOK				748 OLD SALISBURY ROAI EXINGTON, NC 27295	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION IVE ACTION SHOULD B CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 758	 AM. She stated she e always monitor for ad looked for the evidend behaviors and side eff physician notes, nursi service notes if applic Consultant was unable recommend the need and side effect monitor. The Administrator was 12:25 PM and stated was having any issue medication monitoring. 2) Resident #14 was facility on 10/3/19 with 4/9/21. Her diagnoses stroke, and major dep Resident #14's physic order dated 4/9/21 for antidepressant) 25 min The annual Minimum assessment dated 8/7 #14 was cognitively in behavior issues. Her tired or having little er 14 day look back peridays of an antidepress 	sident prescribed ions. with the Pharmacy ucted on 12/2/21 at 11:45 expected the facility staff to liverse side effects and she ce of identified target fect monitoring in the ing notes and psychological cable. The Pharmacy le explain why she did not to identify target behaviors oring in her reviews. s interviewed on 12/2/21 at the was not aware the facility es with psychotropic g. originally admitted to the h a readmission date of s included a history of a oressive disorder. cian orders included an r Sertraline (an illigrams by mouth daily. Data Set (MDS) 16/21 indicated Resident thatct and displayed no mood was coded as feeling hergy 7 to 11 days during the od. Resident #14 received 7	F	758				

Facility ID: 923187

If continuation sheet Page 46 of 75

CENTER	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES	1			FORM OMB NC	D: 01/06/2022 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í				SURVEY PLETED
		345066	B. WING				02/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON	3ROOK				1748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	area for history of cryi antidepressant. The ir monitor patterns of tar adverse side effects, a administer medication effectiveness. Review of the Pharma review notes for resid November 2021 did n monitoring targeted by A review of Resident a notes from 9/1/21 to 1 of refusing medication Resident #14's Medic Records (MARs) from she received Sertralin not list any targeted b nor side effects that m medication. An interview was cond Nursing (DON) on 11/ stated Resident #14's effect monitoring was the nursing notes and sheets, which were no She explained the fac identify target behavio entering an order for a into the electronic me the "special requireme completed when the r the EMR, it would app however she felt either the two software prog	ing spells and receives an interventions included to rgeted behaviors, assess for document, and report, and a sordered monitoring for acy Consultant medication ent #14 from June 2021 to not reflect the need for ehaviors or side effects. #14's nursing progress 12/1/21 included a behavior as at times. eation Administration a 9/1/21 to present indicated be as ordered. The MAR did behaviors for staff to monitor hay be displayed from the ducted with the Director of /30/21 at 1:32 PM. She a target behaviors and side documented if observed in a on the nursing acute of part of the medical record. cility had the capability to ors and side effects when a psychotropic medication dical record (EMR) under	F	758			

Facility ID: 923187

If continuation sheet Page 47 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	01/06/2022 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE S COMPL	SURVEY ETED
		345066	B. WING			C 12/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP	CODE		
ALSTON	BROOK			748 OLD SALISBURY ROAD EXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE		(X5) COMPLETION DATE
F 758	medications weekly w (NM). She stated she identifying target beha side effects of psycho On 11/30/21 at 3:15 F conducted with the Ni the psychotropic med physician regarding th reductions, but target monitoring was not di only documenting the NM stated she was no required identified target the facility did not rou but the nurse would of changes noted in the software system for c "special requirements target behaviors could software programs did each other. On 12/1/21 at 12:30 F observed completing very engaging and ha On 12/1/21 at 1:35 Pf with Nurse #2. She s was familiar with Resi crying or tearfulness. there was not a speci monitored on the MAI order, however if she behaviors, it would be	eviewed all the psychotropic vith the Nurse Manager was aware of the need for aviors and monitoring for otropic medications. PM, an interview was M, who stated she was over ications and worked with the ne need for gradual dose behaviors and side effect scussed as the nurses were se areas if observed. The ot aware that psychotropics get behaviors. She stated tinely monitor for side effect, contact the physician for any resident. The NM added the harting had a tab called " in which side effects and d be identified but the two d not communicate with PM, Resident #14 was her lunch meal. She was	F 758				

If continuation sheet Page 48 of 75

-		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/06/2022 APPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345066	B. WING					C 02/2021
NAME OF PROVIDER OR	SUPPLIER		•	Ş	STREET ADDRESS, CITY, STATE, ZII	P CODE		
ALSTON BROOK				4	4748 OLD SALISBURY ROAD			
ALSTON BROOK					LEXINGTON, NC 27295			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD B		(X5) COMPLETION DATE
An intervi Physician who expla to report is behaviors medication target bel documen effect mo psychotro A telepho Pharmacy She state always m referred to psycholog evidence The Phar why she of target bel reviews. The Admi 12:25 PW was havin medication 3) Reside 10/27/21 depressiv	I's Assistant ained she de if Resident # s or side effe on. She furth haviors shou ted, and mo nitoring for a opic medicat ne interview y Consultant ed she expect onitor for ad o nursing no gical service of identified macy Consu did not recorn haviors and inistrator wa I and stated ng any issue on monitoring ent #67 was with diagnos re disorder, a of Resident an order dat epressant) 1	appleted with the facility (PA) on 12/1/21 at 2:45 PM, epended on the nursing staff 14 was displaying any cts to the antidepressant her stated she was aware and be identified, nitored, as well as side any resident prescribed ions. • was completed with the c on 12/2/21 at 11:45 AM. • ted the facility staff to verse side effects and she tes, physician notes and notes, if applicable, for behaviors and side effects. • and the need to identify side effect monitoring in her s interviewed on 12/2/21 at he was not aware the facility s with psychotropic	F	758				

Facility ID: 923187

If continuation sheet Page 49 of 75

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/06/2022 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345066	B. WING				C 102/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON I	3ROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	 #67 had severe cogni displayed no behavior coded as feeling tired days during the 14 da Resident #67 received antidepressant. A review of Resident a revealed a focus area medication due to his depression disorder. To to monitor patterns of for adverse side effect and administer medic Review of the Pharma review notes for resid to November 2021 dia monitoring targeted b A review of Resident a notes from 10/27/21 to behaviors such as no statements. Resident #67's Medic Records (MARs) from indicated she received The MAR did not list a staff to monitor nor sid displayed from the medication On 11/30/21 at 9:30 A observed sitting in her was engaging but kep 	 /3/21 indicated Resident itive impairment and r issues. Her mood was or having little energy 2 to 6 ay look back period. d 7 days of an #67's active care plan a for use of antidepressant tory of recurrent major The interventions included targeted behaviors, assess ets, document, and report, ations as ordered. acy Consultant medication lent #67 from October 2021 d not reflect the need for ehaviors or side effects. #67's nursing progress to 12/1/21 included ncompliance and repetitive action Administration 10/27/21 to present d Citalopram as ordered. any targeted behaviors for de effects that may be edication. AM, Resident #67 was r wheelchair at bedside. She of stating she had to get as coming and wanted to 	F	758			

Facility ID: 923187

If continuation sheet Page 50 of 75

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 01/06/2022 APPROVED 0: 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345066	B. WING		_	(12/0	C 02/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
	BOOK			4748 OLD SALISBURY RO	AD		
ALSTON E	SRUUK			LEXINGTON, NC 27295	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Nursing (DON) on 11/ stated Resident #67's effect monitoring was the nursing notes and sheets, which were no She explained the fac- identify target behavio entering an order for a into the electronic me the "special requireme completed when the r the EMR, it would app however she felt eithe the two software prog not communicate with stated the physician r medications weekly w (NM). She stated she identifying target beha side effects of psycho On 11/30/21 at 3:15 F conducted with the NI the psychotropic med physician regarding th reductions, but target monitoring was not di only documenting the NM stated she was no required identified targ the facility did not rou but the nurse would c changes noted in the software system for c "special requirements target behaviors could	ducted with the Director of 30/21 at 1:32 PM. She target behaviors and side documented if observed in on the nursing acute of part of the medical record. ility had the capability to ors and side effects when a psychotropic medication dical record (EMR) under ents" tab. If this was nedication was entered in bear on the resident's MAR, or this was not being done or rams the facility used did each other. The DON eviewed all the psychotropic ith the Nurse Manager was aware of the need for aviors and monitoring for tropic medications.	F 75	8			

If continuation sheet Page 51 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/06/2022 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345066	B. WING		_		C 02/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ALSTON E	REOOK			4748 OLD SALISBURY RO	AD		
ALSTON	SKOOK			LEXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	51	F 758	3			
		/l, an interview occurred rse Aide #8. They both					
		ecame more agitated after					
		o home, trying to find her					
		er husband was waiting for here was not a specific					
		t monitored on the MAR or					
	on the Physician's or						
		of any behaviors, it would nursing progress notes					
	and reported to the ph						
	An interview was com	pleted with the facility (PA) on 12/1/221 at 2:45					
	-	he depended on the nursing					
	staff to report if Resid	ent #67 was displaying any					
		cts to the antidepressant er stated she was aware					
	target behaviors shou						
		nitored and there should be					
	-	for any resident prescribed					
	psychotropic medicati	ons.					
	A telephone interview	with the Pharmacy					
	-	ucted on 12/2/21 at 11:45					
		xpected the facility staff to					
	always monitor for ad looked for the evidence	verse side effects and she					
	behaviors and side ef						
		ng notes and psychological					
	service notes if applic	-					
		e explain why she did not to identify target behaviors					
	and side effect monito						
		s interviewed on 12/2/21 at					
	12:25 PM and stated was having any issue	he was not aware the facility s with psychotropic					

Facility ID: 923187

If continuation sheet Page 52 of 75

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345066	B. WING				C / 02/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALSTON E	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From page medication monitoring		F	758	3		
	included orders dated antidepressant) 100 r	#81's physician orders I 11/8/21 for Bupropion (an nilligrams (mg) by mouth ipiprazole (an antipsychotic) a day.					
		um Data Set (MDS) /15/21 indicated Resident ntact and displayed no mood					
	problem area for a his depression. The inter administer medication patterns of targeted b						
	review notes for resid	acy Consultant medication ent #81 from November ne need for monitoring side effects.					
		#81's nursing progress 12/1/21 included no mood					

Facility ID: 923187

If continuation sheet Page 53 of 75

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 01/06/2022 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY LETED
		345066	B. WING		_	(12/0	; 02/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ALSTON I	PROOK			4748 OLD SALISBURY RO	AD		
ALSTON	BROOK			LEXINGTON, NC 27295	5		
(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 BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	behaviors for staff to r may be displayed from On 11/29/21 at 10:50 observed sitting in a w stated he was working returning home. He do sadness and stated h when he was having a once he received his breath the anxiety wa An interview was come Nursing (DON) on 11/ stated Resident #81's effect monitoring was the nursing notes and sheets, which were no She explained the fac identify target behavior entering an order for a into the electronic me the "special requireme completed when the r the EMR, it would app however she felt either the two software prog not communicate with stated the physician r medications weekly w (NM). She stated she identifying target behavior on 11/30/21 at 3:15 F conducted with the NI the psychotropic med physician regarding th	monitor nor side effects that in the medications. AM, Resident #81 was wheelchair at bedside. He g with therapy in hopes of lenied any feelings of e only became anxious a hard time breathing but medications for shortness of s gone. ducted with the Director of 30/21 at 1:32 PM. She target behaviors and side documented if observed in on the nursing acute of part of the medical record. illity had the capability to ors and side effects when a psychotropic medication dical record (EMR) under ents" tab. If this was medication was entered in bear on the resident's MAR, er this was not being done or rams the facility used did a each other. The DON eviewed all the psychotropic rith the Nurse Manager was aware of the need for aviors and monitoring for tropic medications.	F 7	58			

Facility ID: 923187

If continuation sheet Page 54 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345066	B. WING				C 102/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
ALSTON	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 758	monitoring was not di only documenting the NM stated she was me required identified tar the facility did not rou but the nurse would of changes noted in the software system for of "special requirements" target behaviors could software programs dir each other. On 12/1/21 at 1:50 Pf with Nurse #3. She si displayed any type of She further stated the behavior or side effect on the Physician orde or was told of any bel documented in the nu- reported to the physic An interview was com- Physician's Assistant PM, who explained sh staff to report if Resid behaviors or side effect antipsychotic medicat was aware target beh documented, and mo side effect monitoring psychotropic medicat A telephone interview Consultant was condu-	scussed as the nurses were se areas if observed. The ot aware that psychotropics get behaviors. She stated tinely monitor for side effect, ontact the physician for any resident. The NM added the harting had a tab called " in which side effects and d be identified but the two d not communicate with M, an interview occurred tated Resident #81 had not mood or behavior concerns. ere was not a specific at monitored on the MAR or ers, however if she observed haviors, it would be ursing progress notes and cian as needed. hpleted with the facility (PA) on 12/1/221 at 2:45 he depended on the nursing ent #81 was displaying any tots to the antidepressant or tions. She further stated she haviors should be identified, nitored and there should be for any resident prescribed ions.	F	758	3		

If continuation sheet Page 55 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/06/2022 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345066	B. WING		_	(12/0	02/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	·		
ALSTON	BROOK			748 OLD SALISBURY RO EXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	behaviors and side ef physician notes, nursi service notes if applic Consultant was unable recommend the need and side effect monito The Administrator was 12:25 PM and stated was having any issue medication monitoring 5. Resident #69 admi diagnosis of vascular disturbance. The quarterly Minimu 11/1/21 indicated Res cognitive impairments behaviors during the the assessment. He v taking an antipsychot Review of Resident # Physician orders inclu 25 milligrams (mg) ev every night at bedtime Review of Resident # administration records November 2021 indic Seroquel as ordered. identified target behav monitoring for side eff Review of Resident # 6/1/21 to 11/30/21 inclustors behaviors: grabbing for	ffect monitoring in the ing notes and psychological cable. The Pharmacy le explain why she did not l to identify target behaviors oring in her reviews. s interviewed on 12/2/21 at he was not aware the facility es with psychotropic g. itted on 9/15/20 with a dementia with behavioral m Data Set (MDS) dated sident #69 had severe s and he exhibited no 7 day look back period for was coded as taking as ic on a routine basis. 469's November 2021 uded the following: Seroquel very morning and 25 mg e. 469's medication s from June 2021 to cated he received his There was no evidence of viors and no evidence of fects.	F 758				

Facility ID: 923187

If continuation sheet Page 56 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/06/2022 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345066	B. WING		-	(12/	C 02/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
			4	748 OLD SALISBURY ROA	ND		
ALSTON E	BROOK		L	EXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 EFICIENCY)		(X5) COMPLETION DATE
F 758	roommates urinary car release. Observation on 11/29 #69 was in his room s was cooperative and agitation, wandering of An interview was come Nursing (DON) on 11/ stated Resident #69's effects monitoring wear in the nursing notes a sheets that were not p stated the facility had target behaviors and s physician order for a p electronic medical reor "special requirements the resident's MAR bu- being done or the two facility used, did not c other. The DON state worked weekly with p antipsychotic medicat aware of the need for and monitoring for sid medications. An interview was come 11/30/21 at 3:15 PM. the psychotropic med providers regarding th reductions for antipsy behaviors and side eff	ing feces and grabbing his theter bag and refusing to /21 at 1:18 PM, Resident itting in his wheelchair. He did not exhibit any signs of or aggression. ducted with the Director of 30/21 at 1:32 PM. She target behaviors and side re documented by exception nd on the nursing acute beart of the record. She the capability to identify side effects when entering a beychotropic into the ord (EMR) under the " tab so it would appear on at that was apparently not software programs the ommunicate with each d the Nurse Manger (NM) roviders to discuss ions. She stated she was identifying targe behaviors e effects of psychotropic ducted with the NM on She stated she was over ications and worked the he need for gradual dose chotics. She stated target fects monitoring were not	F 758	D	EFICIENCY)		
		e nurses only documenting eption. The NM stated she sychotropics required					

Facility ID: 923187

If continuation sheet Page 57 of 75

			(1 APPROVED 0. 0938-0391
	,			(X3) DATE COMP	SURVEY LETED
15066 B.	. WING		-		C 02/2021
•		STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		4748 OLD SALISBURY ROA	AD		
		LEXINGTON, NC 27295			
ED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
nurse would e resident. for charting ss" in which ld be ims do not tated the ogged into see #4 on dent #69 seeking ed the female identified ie Physician o side effect ysician oserved a aviors, she stated she eted e of an monitoring alking an sing AM. She sident #69. ad observed nt rooms and sing any PA on depended on	F 75	3			
	JPPLIER/CLIA (X DN NUMBER: A	JPPLIER/CLIA DN NUMBER: (X2) MULTIPL A. BUILDING 45066 B. WING IENCIES DED BY FULL IFORMATION) IENCIES DED BY FULL IFORMATION) F 758 d the facility nurse would the resident. F 758 d the facility nurse would the resident. F 758 for charting ts" in which and be arms do not tated the bogged into rse #4 on dent #69 seeking ed the female identified the female the female the female	JPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING	JPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING	JPPLIERICLIA NNUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) DATE COMP 45066 B. WING (2) 45067 D (2) 45068 D (2) 45069 D (2) 45060 D (2) 45061 D (2) 45062 D (2) 45063 D (2) 45064 D (2) 45065 D PROVIDERS PLAN OF CORRECTION INDUID BE 4507 D CROSS-REFERENCED TO THE APPROPRIATE 121 D D 121 D D 121 D D 122 D D <tr< td=""></tr<>

Facility ID: 923187

If continuation sheet Page 58 of 75

CENTERS FOR MEDICARE & MI	EDICAID SERVICES					APPROVED 0.0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
	345066	B. WING				02/2021
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON BROOK				1748 OLD SALISBURY ROAD EXINGTON, NC 27295		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
 documented and monitoring for psychotropic medication A telephone interview with Pharmacist was conduct AM. The Consultant Ph doing her monthly reviet the MARs to ensure tarrside effects were monitoring for the MARs to ensure the MARs to ensure the facility was having any immedications. An interview with the Act 12:25 PM. He stated her facility was having any immedications. Resident #34 was add anxiety and depression Her quarterly Minimum 9/30/21 indicated she with she exhibited no behavion period for the assessme coded for taking antianom medications. Review of Resident #34 Physician orders includ 0.25 milligrams (mg) evand at bedtime and We a day. Review of Resident #34 administration records for November 2021 indicated for the assessme coded for taking antianom medication for the assessme coded for taking antianom medications. 	ent prescribed a ns. She stated she was viors should be identified, ored and there should be or any resident prescribed ns. with the Consultant cted on 12/2/21 at 11:45 harmacist stated when ew, it was difficult to review get behaviors and adverse ored on a daily basis. dministrator on 12/2/21 at e was not aware that the issues with psychotropic dmitted 4/12/18 with of the base cognitively intact and viors in the 7 day look back ent. Resident #34 was xiety and antidepressant 4's November 2021 ted the following: Xanax very morning, afternoon ellbutrin 150mg three times 4's medication from June 2021 to	F	758			

Facility ID: 923187

If continuation sheet Page 59 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/06/2022 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345066	B. WING		_	(12/0) 02/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ALSTON E	BROOK			748 OLD SALISBURY RO EXINGTON, NC 27295.			
(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 CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	evidence of monitorin Review of Resident # 6/1/21 to 11/30/21 inc behaviors: no docume 2021, August 2021, S October 2021. Nursin 11/15/21, 11/19/21 an tearful. An interview was come Nursing (DON) on 11/ stated Resident #34's effects monitoring we in the nursing notes a sheets that were not p stated the facility had target behaviors and s physician order for a p electronic medical rec "special requirements the resident's MAR bu being done or the two facility used, did not c other. The DON state worked weekly with p psychotropic medicati aware of the need for and monitoring for sid medications. An interview was come 11/30/21 at 3:15 PM. the psychotropic med providers. The NM state meetings, only the an She stated target beh	target behaviors and no g for side effects. 34's nursing notes from Juded the following ented behaviors in June beptember 2021 and g notes dated 7/29/21, id 11/22/21 read she was ducted with the Director of (30/21 at 1:32 PM. She target behaviors and side re documented by exception and on the nursing acute beat of the record. She the capability to identify side effects when entering a psychotropic into the cord (EMR) under the " tab so it would appear on ut that was apparently not o software programs the communicate with each d the Nurse Manger (NM)	F 758				

Facility ID: 923187

If continuation sheet Page 60 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/06/2022 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345066	B. WING				C / 02/2021
NAME OF P	ROVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	nurses only documen exception. The NM st psychotropics require She stated the facility monitoring but the nur for any changes in the the software system f "special requirements target behaviors could software programs do each other. She state know unless they logg An observation and in 12/1/21 at 10:40 AM. room lying in bed. She herself lately and note A telephone interview Pharmacist was cond AM. The Consultant F doing her monthly rev the MARs to ensure to side effects were mor was unable to explain identified the needed monitoring. An interview was con- 12/1/21 at 3:55 PM. S Resident #34 has bee of taking her things at was discovered that F her clothes in the tras retrieve it. She stated Resident #34 being te An interview was con-	ting behaviors only by cated she was not aware that didentified target behaviors. did no side effect rse would contact the MD e resident. The NM stated for charting has a tab called s'' in which side effects and d be identified but the two ponot communicate with ed the nurses would not ged into the other program. hterview was conducted on Resident #34 was in her e stated she had not felt like ed more confusion. with the Consultant fucted on 12/2/21 at 11:45 Pharmacist stated when view, it was difficult to review arget behaviors and adverse hitored on a daily basis. She n why she nor the facility psychotropic medication ducted with NA #5 on She stated recently, en accusing other residents ind clothing. NA #5 stated it Resident #34 was throwing sh and staff had to go she had not observed	F	758	3		

Facility ID: 923187

If continuation sheet Page 61 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/06/2022 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345066	B. WING				C 2/ 02/2021
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 758	observed any evidence she had noted an incr accusing other reside She stated it was felt some dementia. An interview with the 12/1/21 at 9:44 AM. S information about Res her family. The NP st monitor for adverse si medications to include stated if the facility ha program, it was would much for the nurses to software programs an NP stated she felt the with the events that h pandemic along with in some things being An observation of Res on 12/2/21 at 11:20 A her sister at the beds Resident #34 was nation nurse had given her si #34's sister stated sho this morning and it ma An interview with the 12:25 PM. He stated facility was having an medications. 7. Resident #17 was a diagnosis of depression	ce of agitation or crying but rease in Resident #34 ents messing with her things. that she was developing NP was conducted on She stated she obtained her sident #34 from the staff and tated the facility staff should ide effects for all e psychotropics. The NP ad a different software d be helpful but it was too o work in two different ad also the hard chart. The e staff were overwhelmed ave occurred during staff turnover and it resulted missed. sident #34 was conducted M. She was lying in bed with side. Her sister stated useous this morning and the something for it. Resident e started a new medication ay be making her nauseous. Administrator on 12/2/21 at he was not aware that the y issues with psychotropic	F	758	В		

If continuation sheet Page 62 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/06/2022 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345066	B. WING				C / 02/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4	4748 OLD SALISBURY ROAD		
ALSTON E	BROOK			ι	LEXINGTON, NC 27295		
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 758	period for the assess coded for taking antid Review of Resident # Physician orders inclu 60 milligrams (mg) on Review of Resident # administration records November 2021 indic Cymbalta as ordered. identified target behave monitoring for side eff Review of Resident # 6/1/21 to 11/30/21 did documentation regard An observation and in was conducted on 11/ in bed playing on a la complimentary of the no concerns. An interview was comp Nursing (DON) on 11/ stated Resident #17's effects monitoring we in the nursing notes a sheets that were not p stated the facility had target behaviors and s physician order for a p electronic medical rec "special requirements the resident's MAR bu being done or the two	s in the 7 day look back ment. Resident #17 was epressant medications. 17's November 2021 ided the following: Cymbalta ice daily. 17's medication s from June 2021 to ated he received his There was no evidence of viors and no evidence of viors and no evidence of fects. 17's nursing notes from not include any ling any behaviors. Aterview with Resident #17 730/21 at 9:41 AM. He lying ptop. Resident #17 was facility and staff. He voiced ducted with the Director of 730/21 at 1:32 PM. She target behaviors and side re documented by exception nd on the nursing acute part of the record. She the capability to identify side effects when entering a psychotropic into the cord (EMR) under the " tab so it would appear on ut that was apparently not s software programs the	F	758			
	"special requirements the resident's MAR bu being done or the two	" tab so it would appear on ut that was apparently not					

Facility ID: 923187

If continuation sheet Page 63 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345066	B. WING				C /02/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALSTON E	BROOK				1748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	other. The DON state worked weekly with p psychotropic medicati aware of the need for and monitoring for sid medications. An interview was com- 11/30/21 at 3:15 PM. the psychotropic medi providers. The NM state meetings, only the an She stated target beh monitoring were not of nurses only document exception. The NM state psychotropics require She stated the facility monitoring but the nut for any changes in the the software system f "special requirements" target behaviors could software programs do each other. She state know unless they logg A telephone interview Pharmacist was cond AM. The Consultant F doing her monthly rev the MARs to ensure ta side effects were mor An interview was con- 12/1/21 at 2:45 PM. S the nurses to tell her v exhibited for any reside	d the Nurse Manger (NM) roviders to discuss ions. She stated she was i dentifying targe behaviors de effects of psychotropic ducted with the NM on She stated she was over lications and worked the ated during the weekly tipsychotics were discussed. aviors and side effects discussed because the ting behaviors only by ated she was not aware that didentified target behaviors. did no side effect rse would contact the MD e resident. The NM stated for charting has a tab called " in which side effects and d be identified but the two o not communicate with d the nurses would not ged into the other program. with the Consultant fucted on 12/2/21 at 11:45 Pharmacist stated when view, it was difficult to review arget behaviors and adverse nitored on a daily basis.	F	758			

Facility ID: 923187

If continuation sheet Page 64 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/06/2022 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345066	B. WING				C / 02/2021
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON I	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	documented and mon side effect monitoring psychotropic medicati An interview was cond 12/2/21 at 9:10 AM. S inappropriate with the when a female batheor not observed any cryi loss of appetite. An interview was cond 12/2/21 at 9:15 AM. S not exhibit any eviden changes in his appetit refused care but agre An interview with the 12:25 PM. He stated I facility was having any medications. 8. Resident #28 was a 6/28/17 with multiple depressive disorder a Minimum Data Set (M 9/20/21 indicated that was intact, and she ha and antidepressant m the assessment perio Resident #28 has doc 0.125 milligrams (mgs day for anxiety and Le tablet by mouth daily	aviors should be identified, itored and there should be for any resident prescribed ons. ducted with NA #10 on the stated Resident #17 was female staff and loved it d him. She stated she was ng, sadness, agitation or ducted with Nurse #1 on the stated Resident #17 did ice of sadness, crying or te but he occasionally ed with reapproach. Administrator on 12/2/21 at ne was not aware that the y issues with psychotropic admitted to the facility on diagnoses including major nd anxiety. The annual IDS) assessment dated Resident #28's cognition as received an antianxiety edications for 7 days during d. tor's orders for Clonazepam s) 1 tablet by mouth twice a exapro 10 mgs - 1 and ½ for depression on 9/23/21. .5 mgs 1 tablet by mouth 3	F	758			

If continuation sheet Page 65 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/06/2022 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345066	B. WING				C 02/2021
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4	4748 OLD SALISBURY ROAD		
ALSTON E	BROOK			L	LEXINGTON, NC 27295		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	65	F	758	3		
	Review of Resident # revealed no documen effects and target beh	tation of monitoring of side					
	Nursing (DON) on 11/ stated that target beh monitoring were docu nursing notes and on which were not part of explained the facility if target behaviors and an order for a psycho electronic medical red "special requirements when the medication would appear on the Administration Record either this was not be programs the facility of with each other. The reviewed all the psych	Immented if observed in the the nursing acute sheets, f the medical record. She had the capability to monitor side effects when entering tropic medication into the cord (EMR) under the " tab. If this was completed was entered in the EMR, it					
	monitoring for side eff medications. On 11/30/21 at 3:15 F conducted with the N stated she was over t and worked with the p for gradual dose redu and side effect monito the nurses were only observed. The NM sta psychotropics require behaviors and the fact	PM, an interview was urse Manager (NM), who he psychotropic medications ohysician regarding the need ctions, but target behaviors oring were not discussed, as documenting these areas if ated she was not aware that					

Facility ID: 923187

If continuation sheet Page 66 of 75

	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	D: 01/06/2022 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>			(X3) DATE COMP	SURVEY LETED
		345066	B. WING				C 02/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
ALSTON	BROOK				748 OLD SALISBURY ROAD EXINGTON, NC 27295		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 758	 physician for any chai The NM added the so had a tab called "spec side effects and targe monitored but the two communicate with ead On 12/1/21 at 1:35 PM with Nurse #2. Nurse specific behavior or si MAR, however if she behaviors, it would be progress notes and re needed. An interview was com Practitioner (NP) on 1 explained she relied of if the resident was dis side effects to the psy further stated she was should be identified, r and there should be s resident prescribed ps The Administrator was 12:25 PM and stated was having any issue medication monitoring 9. Resident #6 was ac 6/16/21 with multiple of depression and anxie Data Set (MDS) asse- indicated that Resider cognitive impairment 	nges noted in the resident. oftware system for charting cial requirements" in which at behaviors could be o software programs did not ch other. W, an interview occurred a #2 stated there was no ide effect monitoring on the observed or was told of any a documented in the nursing eported to the physician as npleted with Nurse 12/2/21 at 9:45 AM, who on the nursing staff to report splaying any behaviors or v/chotropic medication. She s aware target behaviors monitored and documented, side effect monitoring for any sychotropic medications. s interviewed on 12/2/21 at he was not aware the facility as with psychotropic g. dmitted to the facility on diagnoses including ity. The quarterly Minimum ssment dated 8/11/21 nt #6 has moderate	F	758			

Facility ID: 923187

If continuation sheet Page 67 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/06/2022 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE COMPI	SURVEY _ETED
		345066	B. WING			(12/() 2/2021
NAME OF PR	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
			4	748 OLD SALISBURY ROAI	D		
ALSTON E	SRUUK		L	EXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page days during the asses Resident #6 has doct		F 758				
	1 tablet by mouth dail and for Klonopin 0.5 r bedtime for anxiety or	y for depression on 6/16/21 ngs 1 tablet by mouth at n 8/1/21.					
	no documentation of r and target behaviors.	6 medical records revealed nonitoring of side effects					
	Nursing (DON) on 11/ stated that target behaviors nursing notes and on which were not part of explained the facility fit target behaviors and s an order for a psychol electronic medical rec "special requirements when the medication would appear on the of Administration Record either this was not be programs the facility of with each other. The fit reviewed all the psych with the Nurse Manage	mented if observed in the the nursing acute sheets, f the medical record. She had the capability to monitor side effects when entering tropic medication into the ord (EMR) under the " tab. If this was completed was entered in the EMR, it resident's Medication ds (MARs), however she felt ing done or the two software used did not communicate DON stated the physician notropic medications weekly yer (NM) and was aware of g target behaviors and					
	medications. On 11/30/21 at 3:15 F conducted with the Ne stated she was over t and worked with the p						

Facility ID: 923187

If continuation sheet Page 68 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/06/2022 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345066	B. WING				C 02/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALSTON E	BROOK			4	748 OLD SALISBURY ROAD		
				L	EXINGTON, NC 27295		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page and side effect monito the nurses were only observed. The NM sta psychotropics require and the facility did noi effects, but the nurse for any changes note added the software sy called "special require and target behaviors two software program each other. On 12/1/21 at 1:35 PP with Nurse #2. Nurse specific behavior or si MAR, however if she behaviors, it would be progress notes and re needed. An interview was com Practitioner (NP) on 1 explained she relied of if the resident was dis side effects to the psy further stated she was should be identified, r and there should be s resident prescribed psy The Administrator was 12:25 PM and stated was having any issue medication monitoring	e 68 bring were not discussed, as documenting these areas if ated she was not aware that d target behavior monitoring t routinely monitor for side would contact the physician d in the resident. The NM ystem for charting had a tab ements" in which side effects could be monitored but the is did not communicate with M, an interview occurred #2 stated there was no ide effect monitored on the observed or was told of any e documented in the nursing eported to the physician as hpleted with Nurse 2/2/21 at 9:45 AM, who on the nursing staff to report splaying any behaviors or rechotropic medication. She is aware target behaviors monitored and documented, ide effect monitoring for any sychotropic medications.	F	758	DEFICIENCY)		12/30/21
F 759 SS=D	Free of Medication Er CFR(s): 483.45(f)(1)	ror Rts 5 Prcnt or More	F	759			12/30/21

Facility ID: 923187

If continuation sheet Page 69 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM): 01/06/2022 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345066	B. WING		12/	C 02/2021
NAME OF P	ROVIDER OR SUPPLIER		S	IREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
			47	748 OLD SALISBURY ROAD		
ALSTON E	BROOK		L	EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 759	percent or greater; This REQUIREMENT by: Based on record revie manufacturer's specifi staff interview, the face medication error rate of evidenced by 2 of 29 of medication error rate of observed during medi #27). Findings included: 1. Resident #5 was act 10/29/19. On 5/13/21 order for senna (used milligrams (mgs) 1 tak Resident#5 was obse pass on 12/1/21 at 8:0 Aide (Med. Aide) was administer senna with tablet by mouth to the The Med. Aide was in 9:05 AM. She reporte administers senna wit she was instructed to didn't know that there plus.	Errors. Ire that its- ion error rates are not 5 is not met as evidenced ew and review of the ication, observation, and illity failed to have a of less than 5% as opportunities resulting in a of 6.9% for 2 of 4 residents cation pass (Residents #5 & dmitted to the facility on , the resident has a doctor's to treat constipation) 8.6 olet by mouth daily. rved during the medication 00 AM. The Medication observed to prepare and to attactive 50 mgs/8.6 mgs 1 resident. terviewed on 12/1/21 at ed that she always h laxative to Resident #5 as give. She stated that she was a senna and a senna	F 759	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. On December 3, 2021 the medication aide in question was re-educated by th Staff Development Nurse on the proper administration of a hand held inhaler a the difference between Senna and Ser Plus. Medication Aide was then observe by the Staff Development Nurse to hav correctly administered the hand held inhaler for resident #27 and was obser administering correct dose of Senna to resident #5. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVI THE POTENTIAL TO BE AFFECTED THE SAME DEFICIENT PRACTICE. The medication aide was re-educated December 3, 2021 by the Staff Development Nurse as to the 5 rights of giving medication and the Staff Development Nurse conducted a Competency Assessment on Metered	D ne r nd nna ved ve ved D NG BY on	
	on 12/2/21 at 1:08 PM	ng (DON) was interviewed 1. She stated that she uding the Med Aides to		Dose Inhaler. The Pharmacist Consult conducted a Med Pass Review on December 15, 2021 for medication aid		

Facility ID: 923187

If continuation sheet Page 70 of 75

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345066 B. WING 12/02/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 759 Continued From page 70 F 759 follow doctor's orders. question with 0% error rate. In addition the Pharmacist Consultant conducted Med Pass Reviews on two addition nurses with 2. The manufacturer's specification for Symbicort 0% error rate which included residents with hand held inhaler. indicated "if your prescribed dose is 2 puffs, wait at least one minute between them" ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC Resident #27 was admitted to the facility on 6/14/21. On 10/27/21, the resident has a doctor's CHANGES MADE TO ENSURE THAT order for Symbicort (used to treat chronic THE DEFICIENT PRACTICE WILL NOT RECUR. obstructive pulmonary disease (COPD)) 80-4.5 milligrams (mgs) inhaler - 2 puffs twice a day. The Pharmacist Consultant will conduct Resident #27 was observed during the random monthly Med Pass Reviews medication pass on 12/1/21 at 8:21 AM. The throughout facility. Timers were placed on Med Aide was observed to prepare and to all medication carts as a means of administer 2 puffs of Symbicort to Resident #27. monitoring appropriate time period The Med Aide waited 10 seconds between puffs. between inhaler administrations. On December 15, 2021 all nurses and The Med Aide was interviewed on 12/1/21 at 9:05 medication aides were re-educated on AM. The Med Aide stated that she was supposed proper Medication Administration by the to wait 2-3 minutes between puffs, but she did Staff Development Nurse and RN not. Weekend Nurse Manager. The facility implemented a system where the Staff The Director of Nursing (DON) was interviewed **Development Nurse and RN Weekend** on 12/2/21 at 1:08 PM. She stated that she Nurse Manager will randomly complete a expected nursing including the Med Aides to Med-Pass Review checklist to ensure follow the manufacturer's specification in proper Medication Administration. On administering the inhalers. December 15, 2021 the Staff Development Nurse and RN Weekend Nurse Manager were educated on the implemented system change. All education was required prior to assuming scheduled work assignment. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KV8T11

Facility ID: 923187

If continuation sheet Page 71 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/06/2022 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345066	B. WING				C 102/2021
NAME OF PI	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALSTON E	BROOK				748 OLD SALISBURY ROAD EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 759	Continued From page	• 71	F	759	The Director of Nursing or Designee w review and monitor the Alston Brook Med-Pass Review Checklist by	ill	
					 completing an Alston Brook Med-Pass Review QA Sheet to ensure systemic changes are maintained as follows: 1. Monitor the Med-Pass Review Checklist weekly for 4 weeks 1 Nurse and 1 Med-aide; then 2. Monitor the Med-Pass Review Checklist bi-weekly for 4 weeks1 Nurse and 1 Med-aide; then 3. Monitor the Med-Pass Review Checklist monthly 1 Nurse and 1 Med-aide until resolved by the Quality Assurance Committee. 	9	
					On a quarterly basis the Director of Nursing will present the Quality Assura Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORRECTIN ACTION WILL BE COMPLETED.		
F 947 SS=B	CFR(s): 483.95(g)(1)	Fraining for Nurse Aides -(4) in-service training for nurse	F	947	All re-education and new system will be put into place by December 30, 2021.	e	12/30/21
	aides. In-service training mu §483.95(g)(1) Be suff	st- icient to ensure the ce of nurse aides, but must			cility ID: 923187		t Page 72 of 75

Facility ID: 923187

If continuation sheet Page 72 of 75

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345066	B. WING				C 102/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				4	748 OLD SALISBURY ROAD		
ALSTON E	BROOK			L	EXINGTON, NC 27295		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 947	Continued From page be no less than 12 ho		F	947			
		dementia management abuse prevention training.					
	determined in nurse a						
	to individuals with cog address the care of th This REQUIREMENT by:	rse aides providing services gnitive impairments, also ne cognitively impaired. is not met as evidenced					
	facility failed to provid with annual dementia Nursing Assistants re	ew and staff interviews, the e Nursing Assistants (NAs) training for 5 of 5 sampled viewed for required As #1, #2, #3, #4 and #5).			ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.)	
	The findings included	:			There were no residents directly affected	ed.	
	#1's Education/in-serv	vas 8/7/13. Review of NA vice records indicated no aining since 1/22/2020.			ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVII THE POTENTIAL TO BE AFFECTED I THE SAME DEFICIENT PRACTICE.	NG	
	#2's Education/in-serv	vas 5/12/98. Review of NA vice records indicated no aining since 1/22/2020.			On December 8, 2021 all nurse aides were re-trained on understanding Dementia and Symptoms by the Staff		
	#3's Education/in-sen record of Dementia tr	vas 7/1/15. Review of NA vice records indicated no aining since 1/22/2020.			Development Nurse and provided with handouts for cues and helps needed in dealing with residents with dementia diagnosis.	1	
	#4's Education/in-serv	vas 8/20/19. Review of NA vice records indicated no aining since 1/22/2020.			ADDRESS WHAT MEASURES WILL E PUT INTO PLACE OR SYSTEMIC	3E	

Facility ID: 923187

If continuation sheet Page 73 of 75

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/06/2022 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345066	B. WING			C / 02/2021
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALSTON I	BROOK			1748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
			I			0.(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 947	Continued From page	273	F 947			
	#5's Education/in-ser	vas 6/12/18. Review of NA vice records indicated no aining since 1/22/2020.		CHANGES MADE TO ENSURE TH THE DEFICIENT PRACTICE WILL RECUR.		
				The Annual Training Calendar was		
		n 12/1/21 at 10:30 AM, the pordinator (SDC) stated she		updated to include Dementia training ensure annual training is conducted		
		er the position as SDC in		the authorized time line requirement		
	July 2021 and confirn	ned she had not completed		Monthly schedule of all scheduled tr		
		training since this time		will be posted on the Employee's		
	except for new hires.			Communication Board located by tir clock in the break room. On Decem		
	On 12/1/21 at 10:45 A	AM, the Director of Nursing		15, 2021 the Staff Development Nur		
		nentia training had not		was educated by the Director of Nur	sing	
	occurred since Janua	-		on updating the Annual Training Cal		
		elopment in the past 2 ed it was her expectation for		and posting month training schedule the Employee's Communication Boa		
	all active aides be up	to date with dementia		located by time clock in the break ro		
	training.			INDICATE HOW THE FACILITY PL	ANS	
				TO MONITOR ITS PERFORMANCE		
				MAKE SURE THAT SOLUTIONS AI	RE	
				SUSTAINED.		
				The Director of Nursing or Designee	will	
				review and monitor the Alston Brook	-	
				Annual Training Calendar and Empl	-	
				Communication Board utilizing the A Training Requirements QA Form as	unual	
				follows:		
				1. Monitor the Alston Brook Annua	I	
				Training Calendar and Employee Communication Board weekly for we	ekly	
				for 4 weeks; then	Joiliy	
				2. Monitor the Alston Brook Annua	I	
				Training Calendar and Employee	4	
				Communication Board bi-weekly for weeks e; then	4	
				3. Monitor the Alston Brook Annua	I	

Event ID: KV8T11

Facility ID: 923187

If continuation sheet Page 74 of 75

C 12/02/2021
(X5) COMPLETIC
COMPLETIC
COMPLETIC
ance VE be

Facility ID: 923187

If continuation sheet Page 75 of 75