STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 03/07/2019

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

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F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to include in their abuse policy to report a reasonable suspicion of a crime with resulting serious bodily injury to law enforcement and that all abuse allegations be reported to Health Care Personnel Investigations (state agency) within 2 hours. The findings include: Review of the facility's abuse policy dated January 2019 "Abuse Prevention Program Policies and Procedures" read in part "Procedures: 1. Should an incident or suspected incident of resident abuse, neglect or misappropriation of property be reported, the administrator, or his/her designee, will investigate the alleged incident. 2. The administrator shall ensure that the Health Care Personnel Registry Section of the Division of Health Service Regulation is notified with twenty-four (24) hours or as soon as practicable of all allegations to be related to patient abuse, neglect or	F 607	"On 03/07/2019, Administrator reviewed and revised facility Abuse Prevention Policy to include The Administrator shall ensure that all alleged violations involving suspicion of a crime, abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve suspicion of a crime, abuse or results in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Health Care Personnel Registry Section of the Division of facility Services. Adult Protective Services and Local Law Enforcement are to be notified when warranted. "On 03/07/2019, Administrator initiated an	3/20/19

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

Electronically Signed | 03/20/2019

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F 607	Continued From page 1 misappropriation of patient property." Review of the facility's abuse policy dated January 2019 "Abuse Prevention Program Policies and Procedures" did not include that a reasonable suspicion of a crime with resulting serious bodily injury should be reported to law enforcement when applicable and that all abuse allegations be reported to the state agency within 2 hours. During an interview with the Administrator on 03/07/19 at 3:05 PM, stated that it was an over sight that the facility's abuse policy did not include reporting an abuse allegation to the law enforcement when applicable and reporting an abuse allegations within 2 hours to the state agency. The Administrator further stated that she faxes reported abuse allegations within 2 hours to the state agency and notifies law enforcement when applicable.	F 607	in-service to be conducted by Director of Nursing/Designee for all facility staff on Abuse Prevention Policy focusing on reporting all alleged violations involving suspicion of a crime, abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve suspicion of a crime, abuse or results in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Health Care Personnel Registry Section of the Division of facility Services. Adult Protective Services and Local Law Enforcement are to be notified when warranted. Any staff not in-serviced by 03/07/2019 will be prior to next scheduled shift. "For continued monitoring, random selection of 25% in-house staff to be in-serviced by Director of Nursing/Designee on facility Abuse Prevention Policy with return demonstration to ensure each employee understands facility Abuse Prevention Policy to include all alleged violations involving suspicion of a crime abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve	

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F 607	Continued From page 2	F 607	suspicion of a crime, abuse or results in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Health Care Personnel Registry Section of the Division of facility Services. Adult Protective Services and Local Law Enforcement are to be notified when warranted. Education to continue weekly times 4 weeks to total 100% and monthly thereafter. "All newly employed facility staff will be educated during the orientation process on reviewed and revised Abuse Prevention Policy. "Results and effectiveness of education will be presented at next scheduled Quality Assurance Committee meeting for review and again the following quarterly Quality Assurance Committee Meeting with determination at that time for continued need for monitoring.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to accurately assess a resident's urinary status on the Minimum Data Set (MDS) for one of three residents reviewed for catheters (Resident #5).	F 641	"On 03/07/2019, Administrator in-serviced the Director of Nursing and MDS Coordinator on importance of MDS assessments focusing on certifying the accuracy of the assessment to reflect the	3/20/19

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F 641	Continued From page 3 Findings included: A review of the medical record revealed Resident #5 was admitted 8/7/2017 with diagnoses which included Chronic Obstructive Pulmonary Disease, Diabetes, urinary retention and Coronary Artery Disease. A review of the Admission MDS dated 11/15/2018 revealed in Section H0100 Appliances, "none of the above" was checked. In Section H0300 Urinary Continence was checked "not rated, resident had catheter, urinary ostomy or no urine output for entire 7 days." Because of this, the Care Area Assessment (CAA) automatically checked indwelling catheter, and the care plan initiation was checked manually. The current Minimum Data Set (MDS) was a discharge assessment dated 2/11/2019. The MDS indicated, in Section H 0100 Appliances, "none of the above" was checked. In Section H0300 Urinary Continence was checked "not rated, resident had a catheter, urinary ostomy or no urine output the entire 7 days." Review of the medical record revealed Resident #5 did not have a urinary catheter in place until he returned to the facility on 2/22/2019. There was no care plan for an indwelling catheter in the medical record. On 3/7/2019 at 10:00 AM an observation of Resident #5 was made receiving a bed bath and catheter care. In an interview on 3/7/2019 at 12 noon, the MDS nurse stated she had checked the "not rated"	F 641	resident□s status. "On 03/07/2019, Administrator initiated an audit to be conducted by MDS Coordinator/Designee of most recent MDS assessment for in-house residents to certify the accuracy of the of the assessment to reflect the resident□s status. Any assessments found to have errors are to be corrected and submitted by 03/15/2019. On 03/11/2019, MDS Coordinator spoke with Janet Brooks, MDS/RAI Educational Coordinator and was told facility could not go back and correct the assessment and to ensure the next assessment is corrected to reflect accurate information. "For continued monitoring, random selection of 25% in-house residents most recent MDS Assessment are to be audited by MDS Coordinator/Designee to certify the accuracy of the assessment to reflect the resident□s status. Audit is to continue weekly times 4 weeks to total 100% and monthly thereafter. "All newly employed MDS Coordinators will be educated during the orientation process of MDS requirements/regulations focusing on importance of certifying the accuracy of each MDS assessment to reflect the resident□s status. "Results of audit will be presented at next scheduled Quality Assurance Committee meeting for review and again the following quarterly Quality Assurance Committee	

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F 641	Continued From page 4 area of the urinary assessment by mistake because Resident #5 did not have an indwelling catheter until he returned to the facility on 2/22/2019 from the hospital. The MDS nurse stated she had made the same error on the previous Admission MDS dated 11/15/2018, but Resident #5 did not have a catheter then either. The MDS nurse stated she saw the CAA checked for catheter and checked the care plan initiation. On 3/7/2019 at 12:20 PM, the Administrator stated her expectation was the MDS be accurate.	F 641	Meeting with determination at that time for continued need for monitoring.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		3/20/19

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F 656	Continued From page 5 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to develop a care plan for a resident with a feeding tube for one of three residents reviewed for feeding tubes (Resident #7). The findings included: A review of records revealed Resident #7 was admitted 12/31/2018 with diagnoses of Diabetes Mellitus, Stroke, hemiplegia and anxiety. The Admission Minimum Data Set (MDS) dated 1/11/2019 noted Resident #7 to be impaired for cognition and needed total assistance for all Activities of Daily Living with the physical assistance of one person. The MDS noted Resident #7 had a feeding tube. The Care Area Assessment (CAA) focused on the feeding tube and this area was noted to go to a care plan.	F 656	"On 03/07/2019, MDS Coordinator reviewed and revised the comprehensive care plan for resident # 7. "On 03/07/2019, Administrator in-serviced the Director of Nursing and MDS Coordinator on importance of MDS assessments focusing on ensuring each comprehensive care plan is developed and implemented focusing on person-centered care that includes measurable objectives and time frames to meet the resident□s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. "On 03/07/2019, Administrator initiated an audit to be conducted by MDS Coordinator/Designee of all in-house	

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F 656	Continued From page 6 A review of Resident #7's care plan noted no plan of care for a feeding tube. A review of current physician orders for March 2019 revealed Resident #7 was to have bolus feeds of water 5 times daily. On 3/6/2019 at 2:30 PM the Nurse who was giving care for Resident #7 was interviewed and stated Resident #7 eats three meals daily and gets a bolus feed as well. On 3/7/2019 at 12 noon, the MDS coordinator was interviewed and stated she did not care plan the feeding tube for Resident #7 because the Resident eats food by mouth. The MDS coordinator admitted Resident #7 also gets bolus feed and gets her medications by the feeding tube. The MDS coordinator stated "I just missed it." On 3/7/2019 at 12:20 PM the Administrator stated, in an interview, her expectation was the care plan would be comprehensive and timely.	F 656	residents comprehensive care plan to ensure it is developed and implemented focusing on person-centered care that includes measurable objectives and time frames to meet the resident□s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Audit to be completed by 03/15/2019. "On 03/15/2019, Administrator initiated an IDT review of all in-house residents care plans to compare to CAA and Cardex. IDT will also review the chart to ensure the comprehensive care plan focuses on person-centered care that includes measurable objectives and time frames to meet the resident□s medical, nursing and mental and psychosocial needs. Any comprehensive care plans not reviewed will be by the IDT by 03/20/2019. "For continued monitoring, random selection of 25% in-house residents comprehensive care plan are to be audited by MDS Coordinator/Designee to ensure it is developed and implemented focusing on person-centered care that includes measurable objectives and time frames to meet the resident□s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Audit to continue weekly times 4 weeks to total 100% and monthly thereafter. "All newly employed MDS Coordinators will be educated during the orientation process of MDS requirements/regulations	

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F 656	Continued From page 7	F 656	of a comprehensive care plan that includes developing and implementing a person-centered plan that includes measurable objectives and time frames to meet the resident□s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. "Results of audit will be presented at next scheduled Quality Assurance Committee meeting for review and again the following quarterly Quality Assurance Committee Meeting with determination at that time for continued need for monitoring.	