STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345091	A. BUILDING ______ B. WING ______	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PLACE AT THE VILLAGE AT BROOKWOOD	1820 BROOKWOOD AVENUE BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 12/16/19 through 12/19/19. The facility was found in compliance with requirements CFR 483.73, Emergency Preparedness. Event ID#WO8311.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification Survey with complaint investigation survey was conducted from 12/16/19 through 12/19/19. Event ID# WO8311. 1 of 4 complaints was substantiated without deficiency.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State	F 645		1/16/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/17/2020

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.

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F 645	Continued From page 1	F 645		

intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

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F 645	Continued From page 2 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to submit information for Preadmission Screening and resident review (PASRR) for a Level II evaluation for 1 of 1 resident reviewed for PASRR (Resident #20). The findings included: Resident #20 was admitted to the facility on 11/23/16 with a diagnosis of anxiety disorder, major depressive disorder and post-traumatic stress disorder (PTSD). Review of the annual Minimum Data Set (MDS) assessment dated 7/25/19 revealed Resident #20 was cognitively intact. The MDS further coded the resident as having anxiety disorder, depression, and PTSD. Review of Resident #20 PASRR screen Level I screen dated 5/2/11 identified Resident #20 no mental health diagnosis. Review of Resident #20 PASRR screen notification dated 5/2/11 revealed A PASRR number already existed and the existing PASRR number should be used until it expired. There was no expiration date identified on the PASRR notification. Review of physician order report from 4/1/18 through 12/19/19 revealed Resident #20 began the administration of Prazosin for use of PTSD on 4/11/18.	F 645	1. Social Worker submitted information for Preadmission Screening and Resident Review (PASARR) for a re-evaluation for resident #20 on 01/13/20. New PASARR for resident #20 was received on 01/15/20 and remains a Level 1. 2. Facility completed an audit of current residents Preadmission Screening and Resident Review (PASARR) to ensure that any resident with a new mental health diagnosis(s) had a PASARR evaluation completed and any mental health diagnosis(s) were identified on the current PASARR screen by 01/15/20. Those residents identified that do not have an accurate PASARR evaluation on file will be resubmitted for a new PASARR screening. 3. Administrator provided education to the Social Worker(s) and Admissions Director on the requirements of the Preadmission Screening and Resident Review (PASARR) processing for mental disorders and individuals with intellectual disabilities on 01/16/20. 4. The Social Worker(s) and Admission Director will audit each residents PASARR Screen at the time of admission and then quarterly thereafter. Social Work will	

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F 645	Continued From page 3 Review of Resident #20 care plan revealed a problem start date of 4/11/18 for mood state. The problem further revealed Resident #20 expresses sadness/anger/empathy feelings over lost roles/status feeling of depression with Depakote added as a mood stabilizer. The addition to the note stated 4/11/18 prazosin was added for the diagnosis of PTSD. The goal stated Resident #20 would not exhibit sings of self-concept disturbance. The approaches included determine if mood endangers the resident and intervene if necessary and obtain a psych consult or psychosocial therapy. Review of Resident #20 psychiatric evaluation dated 4/17/18 revealed a chief complaint of depression, anxiety and irritable mood. The evaluation revealed the resident had multiple medical issues and anxiety, depression. Staff report no complaints of function, noting decreased in labile/irritable moods and recent distress related to traumatic history of sexual abuse as a child with nightmares and flashbacks. The note continued that the resident reported no nightmares with recent addition of Prazosin related to PTSDD episode. The note continued that the resident presented consistent with cluster "B" personality. Review of Resident #20 routine physicians visit dated 8/27/18 revealed Resident #20 had been stable for the past month. The note continued that Resident #20 began having increased signs of PTSD and increased agitation. Resident #20 was started on Prazosin for PTSD, been on the medication for several months and was doing well. The assessment/plan stated Prazosin 2 milligrams (mg) by mouth at bedtime for PTSD.	F 645	report the findings of the audits in the QAPI Meetings to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 645	Continued From page 4 Interview with the facility social worker on 12/19/19 at 9:48 AM revealed she was responsible for ensuring resident received a PASRR screening upon admission. She indicated that residents would typically come with a PASRR from the hospital they were being admitted from. She revealed she would submit PASRR screening for residents in the instance they went on hospice, had a significant decline or fracture. She indicated she was unaware if a North Carolina Medicaid uniform screening tool (NCMUST) was required for a level II PASSR screen in the instance a resident obtained a new mental health disorder. Upon observation of Resident #20 PASRR dated 5/2/11 the social worker revealed the PASSAR screen did not match the resident as it did not identify the Residents diagnosis of anxiety, depression or PTSD. Interview with the Administrator on 12/19/19 at 3:44PM revealed the social worker was responsible for resident PASRR. She further indicated in the instance the social worker or the MDS coordinator identified a resident had a new mental health diagnosis the facility would have a discussion regarding if the resident needed to be rescreened for PASRR Level II.	F 645		
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	F 656		1/16/20

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F 656	Continued From page 5 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 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 observation, record review and staff interview, the facility failed to apply Geri-Sleeves as care planned for 1 of 3 (Resident #9) reviewed	F 656	1. The use of Geri-sleeves for resident #9 will be documented on the Electronic Treatment Administration Record (ETAR).	

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F 656 Continued From page 6
for skin condition.

Findings included:

Resident #9 was admitted in the facility on 12/30/12 with a diagnosis that included Alzheimer's disease with late onset, Dermatitis, Edema, and Vascular Dementia. The Minimum Data Set (MDS) dated 10/6/19 revealed the resident has a short term and long-term memory deficit. The resident was coded to have total dependence on bed mobility, transfer, and toilet use. She was also coded to have extensive assistance on dressing and personal hygiene with supervision for eating.

Review of the Weekly Skin Assessment notes dated 12/16/19 revealed scattered bruising to extremities.
The Care Plan dated 9/18/19 revealed Resident #9 had a skin tear to left wrist and left elbow and a Geri sleeves was added in the care to prevent from further skin tear.
An observation on 12/16/19 at 10:28 AM, Resident #9 had a multiple bruise on her upper extremities and there were no Geri sleeves applied. Further observation on 12/17/19 at 1:07 PM showed no Geri sleeves were applied to her upper extremities.

The Nursing Aide #4 (NA) was interviewed on 12/18/19 at 11:20 AM. NA #4 stated that the resident used to have a Geri sleeves about couple weeks ago and that it's not being used now. The NA showed me a copy of a written list of care needed for the resident and Geri sleeves were not included. She stated that all the care needed supposedly included in the list and she admitted that Geri sleeves were not written in the

F 656

Use of the Geri-sleeves will be documented daily by the licensed nurse.

2. The Director of Nursing (DON) completed an audit of residents having the potential to be affected by the same deficient practice on 01/09/20. The use of Geri-sleeves will be documented on the Electronic Treatment Administration Record (ETAR) those residents identified. Use of the Geri-sleeves will be monitored and documented daily by the licensed nurse.

3. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and Unit Managers will reeducate licensed nurses (including weekend and prn licensed nurses) by 01/16/20, regarding implementation of care plan interventions.

4. The Assistant Director of Nursing (ADON) will complete random audits 3 times weekly times one month, then weekly times one month, then monthly thereafter of resident care plan interventions to ensure compliance. The Director of Nursing (DON) will monitor the audit reports on the use of Geri-sleeves. The Director of Nursing (DON) will report the findings of the audits in the QAPI Meetings to ensure compliance. The QAPI committee is responsible for the ongoing compliance.

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F 656	Continued From page 7 care list for Day of the Week print out. An interview with the MDS/Care Plan Coordinator on 12/18/19 at 11:01 AM, she stated that the care plan will show in the resident's Profile Care Plan Approaches. The Care Plan Approaches included all the care needed for the resident listed in the Day of the Week sheet. The MDS Coordinator showed the information in the computer and there were no Geri sleeves written in the profile. The MDS Coordinator further explained that the Geri sleeves were active, and it should show but she was not seeing it in the profile care plan approaches. Interview with the Director of Nursing (DON) was conducted on 12/19/19 at 10:47 AM. The DON stated she looked at the Day of the Week Sheet of the resident this morning and the Geri sleeves were included. The DON was shown a Day of the Week Sheet printed by NA#4 and from the Profile Approaches from the MDS coordinator that did not include the Geri sleeves, and the DON didn't give any reason why it was not showing a day prior. She stated that the Geri sleeves should be listed in the Day of the Week Sheet for the NA's to follow.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		1/16/20

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F 690	Continued From page 8 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to keep the catheter drainage bag lower than the bladder of 1 of 1 resident (Resident # 5) reviewed for catheter care. The findings included: Resident #5 was admitted in the facility on 4/25/16 with a diagnosis that included Multiple Sclerosis and urinary retention. The resident	F 690	1. Resident #5 agreed to wear a leg bag while up in wheelchair to ensure residents dignity and provide proper placement on 01/10/20. While in bed, the drainage bag will remain lower than the bladder. 2. Currently, there are no other residents in the facility with catheters. 3. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and	

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F 690	Continued From page 9 Minimum Data Set (MDS) dated 9/20/19 revealed the resident with a Brief Interview for Mental Status (BIMS) score of 11 with moderate cognition impairment. An observation with Resident #5 on 12/16/19 at 11:44 AM shown the resident was up in the wheelchair in her room. It was observed that her catheter bag was concealed in a black bag hooked in the back of her wheelchair hooked across the push handle higher than her bladder. Other observations were done on 12/17/19 at 9:24 AM and 12:59 PM shown Resident #5 was in her wheelchair and her catheter drainage bag was in the back of her wheelchair. On 12/18/19 at 9:37 AM, Resident #5 was interviewed, and she stated that she kept her catheter drainage bag in a bag on the back of her wheelchair because her husband wanted it hidden. She also stated that nobody had told her to keep the catheter bag lower than her bladder and she further stated that if she had known, she would let the nursing staff position it lower or below her wheelchair. Resident #5 also claimed that she stays up from 6 AM up to 8 PM all the time. The Care Plan for Resident #5 last reviewed on 9/23/19 and indicated in the approaches to keep the catheter drainage bag below the level of the bladder at all times. An interview with the NA #3 was conducted on 12/17/19 at 2:11 PM. She stated that Resident #5 can communicate her needs well to the staff. She further stated that the resident had an indwelling Foley catheter with a drainage bag that is hooked in the back of the resident ' s wheelchair. NA #3	F 690	Unit Managers provided reeducation to licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and certified nursing assistant) by 01/16/20, concerning placement of the catheter drainage bag being lower than the bladder. 4. The Assistant Director of Nursing (ADON) will audit catheter placement 3 times weekly times one month, then weekly times one month then, monthly thereafter for appropriate catheter drainage bag placement. The Director of Nursing (DON) will report the findings of the audits in the QAPI Meetings to ensure compliance. The QAPI committee is responsible for the ongoing compliance.	

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F 690	Continued From page 10 further stated that they placed the catheter in the back of the wheelchair to keep it hidden. Interview with Nurse #3 was done on 12/17/19 2:22 PM and she stated Resident #5 was very oriented and communicates her needs well. She stated that the resident was the one who liked her drainage bag in the back of her wheelchair. She further stated that she was educated with her catheter care. The Director of Nursing (DON) was interviewed on 12/19/19 at 10:40 AM. She stated that the proper way for catheter drainage bag should be lower than the resident ' s bladder.	F 690		