STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036012	A. BUILDING: _____ B. WING _____	R 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE UNION	1717 UNION ROAD GASTONIA, NC 28054

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on November 3, 2015 to November 5, 2015 with an exit conference via telephone on November 6, 2015.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 2 of 5 sampled residents (#1 and #5) were tested for tuberculosis (TB) disease on admission in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. The findings are: A. Review of Resident #5's current FL2 dated 10/14/14 revealed: -Diagnoses that included dementia, congestive heart failure, hypertension, and ischemic heart	D 234		

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disease.
-An admission date of 8/20/14.

Review of Resident #5's record revealed:
-No documentation of any purified protein derivative (PPD) test performed. (PPD is a screening test to determine if someone has been exposed to TB and possibly has an active case of TB.)
-A TB surveillance questionnaire was completed on 10/27/14, more than 2 months after admission, to determine if Resident #5 exhibited any of the symptoms of an active case of tuberculosis.)
-The TB questionnaire was negative for all questions.

Interview with the facility's Health and Wellness Director (HWD) on 11/5/15 at 11:30am revealed:
-The resident was admitted from a skilled nursing facility.
-She had contacted the skilled facility and they were unable to find documentation of any PPD test being performed there.

Refer to facility's policy on tuberculosis screening.

B. Review of Resident #1's current FL2 dated 5/20/15 revealed:
-Diagnoses that included chronic obstructive pulmonary disease, malaise, fatigue, a history of stroke and deep vein thrombosis, and oxygen dependence.
-An admission date of 5/13/15.

Review of Resident #1's record revealed:
-Documentation of a purified protein derivative (PPD) test performed on 4/15/15 at a skilled nursing facility prior to Resident #1's admission to this facility. (PPD is a screening test to determine

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D 234	Continued From page 2	D 234		

if someone has been exposed to TB and possibly has an active case of TB.)
-No other record of any PPD test performed at the facility.
-A TB surveillance questionnaire was completed on 9/22/15, four months after admission, to determine if Resident #1 exhibited any of the symptoms of an active case of tuberculosis.)
-The TB questionnaire was negative for all questions.

Interview with Resident #1 on 11/3/15 at 4:30pm revealed he did not remember ever having a TB test at the other facility or this facility.

Interview with the Health and Wellness Director (HWD) on 11/14/15 at 10:25am revealed she could find no documentation in the resident's record of an additional PPD being performed at this facility.

Refer to facility's policy on tuberculosis screening.

_____

Review of the facility's policy on tuberculosis screening/testing revealed:
-Residents will be screened or tested for tuberculosis (TB) per state guidelines.
-Residents will be tested 3 months prior to admission/move in or within one week following admission/move in.
-Placement of this Mantoux test may be performed by a Registered Nurse (RN) or a Licensed Practical Nurse who has received competency training by an RN.

On 11/5/15 the facility provided the following plan of protection:
-The HWD (an RN) will administer a 2 step TB

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D 234	Continued From page 3 test on residents that do not have documented 2 step TB test within 5 days. - A second step will be administered 21-30 days after the first step. -The HWD will place all residents on a tracker form to ensure 2 step TB tests are given within the permitted time frame. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 21, 2015.	D 234		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure adequate supervision for 1 of 3 (#5) sampled residents with falls. The findings are: Review of Resident #5's current FL2 dated 10/14/14 revealed: -Diagnoses that included dementia, congestive heart failure, hypertension, and ischemic heart disease. -An admission date of 8/20/14.	D 270		

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D 270	Continued From page 4 Interview with the Resident Care Coordinator (RCC) on 11/5/15 at 9:30am revealed a new FL2 had been completed and was awaiting a signature from the facility's new physician scheduled to come to the facility on 11/6/15. Review of Resident #5's record revealed: -A discharge summary from the local emergency room dated 10/21/15 noted fall with head trauma. -A discharge summary from the local emergency room dated 10/16/15 noted closed head injury, skin tear to forearm, acute cystitis. -A discharge summary from the local emergency room dated 10/8/15 noted head injury, open wound to scalp. -A fax to resident's Medical Doctor (MD) dated 10/3/15 noted resident fell from wheelchair, tried to get up unassisted to go to toilet, legs gave out and fell on bottom, no injury. The MD signed off on the fax, but noted no changes. -A fax to the resident's MD dated 8/19/15 noted fall today. The MD signed the fax "noted," but made no changes. -A fax to the resident's MD dated 7/31/15 noted slid off bed into floor, no injury. The MD signed off on the fax but made no changes. -A fax to the resident's MD dated 7/7/15 noted slid off bed trying to get in wheelchair, no injury. The MD signed off on the fax but made no changes. -A fax to the resident's MD dated 5/28/15 noted lost balance transferring from wheelchair to toilet, bottom red, did not want to go to emergency room. The MD signed off on the fax but made no changes. -A fax to the resident's MD dated 5/19/15 noted resident found sitting on floor, stated he slid out of bed, no injury. The MD signed off on the fax but made no changes.	D 270		

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D 270	Continued From page 5 Continued review of Resident #5's record revealed: -A post fall investigation report dated 5/19/15 with no additional intervention added to "decrease risk of future falls/injury." -A post fall investigation report dated 7/20/15 with no additional intervention added to "decrease risk of future falls/injury." -A post fall investigation report dated 7/31/15 with no additional intervention added to "decrease risk of future falls/injury." -A post fall investigation report dated 9/24/15 with no additional intervention added to "decrease risk of future falls/injury." -A post fall investigation report dated 10/3/15 with no additional intervention added to "decrease risk of future falls/injury." -A post fall investigation report dated 10/8/15 with an intervention of "noodle under sheet to define perimeter." -A post fall investigation report dated 10/16/15 with an intervention of "room change due to Resident #5's roommate pushing his wheelchair with decreased safety awareness/ability to assist." -A post fall investigation report dated 10/20/15 with no additional intervention added to "decrease risk of future falls/injury." -A post fall investigation report dated 10/21/15 with no additional intervention added to "decrease risk of future falls/injury." Review of Resident #5's Personal Service Assessment (PSA) dated 10/9/14 revealed: -Resident #5 needed assistance with bathing, dressing and grooming, and toileting. -Toileting included getting on an off the toilet, and pulling up/down pants. -Resident #5 used a mobility device, a wheelchair and walker.	D 270		

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D 270	Continued From page 6 -Transfers were not noted on the assessment. Review of Resident #5's PSA dated 12/5/14 revealed: - Resident #5 had falls within the past 12 months. - Resident #5 used mobility device for ambulation, device not specifically mentioned. -No assistance needed with dressing or grooming. -No assistance needed with toileting. -Assistance needed with bathing. Confidential interviews with 4 staff revealed: -Resident #5 needed assistance with toileting and transfer. -Resident #5 sometimes required 3 staff to transfer, because "he was dead weight." -Resident #5's fall on 10/8/15 required surgical glue to close the head wound, but no stitches or staples. -Resident #5 was on fall precautions, "we check on him every 2 hours and toilet him every 2 hours." -Resident #5 rolled out of bed on several occasions, and the facility placed noodles on top of the mattress and under the sheets to keep him from rolling out of bed. Interview with the facility's Executive Director on 11/5/15 at 5:25pm revealed the following interventions to prevent Resident #5's falls: -Resident #5 was moved to another room because his former roommate tried to "help him" and made him fall out of his wheelchair. -The bad fall on 10/8/15 was caused when Resident #5's roommate pushed him in his wheelchair, and he got his (Resident #5) legs caught under the wheelchair. -The facility placed noodles on Resident #5's bed on 10/9/15 to keep him from rolling out of the	D 270		

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D 270	Continued From page 7	D 270		

bed.
-After any hospitalization, the facility increased supervision of residents to every 30 minutes to an hour, depending on the nature of the injury.
-Resident #5 was scheduled to see the facility's new doctor tomorrow 11/6/15 for an assessment and evaluation of level of care.
-The facility had discussed the possibility of an increase in the level of care with Resident #5's responsible party.

Interview with Resident #5's family member on 11/5/15 at 12:22pm revealed:
-The facility had made the resident's responsible party aware of his falls.
-The family member believed the facility was doing all it could to prevent Resident #5's falls.
-Resident #5 frequently tried to get out of bed at night on his own without assistance.
-The family had been told they may need to consider placement of Resident #5 in a skilled facility.
-Resident #5 fell prior to coming to the facility, and his falls had been much better since he had been at the facility.
-Resident #5 had physical therapy in the facility and it seemed to help with the falls.

Review of Resident #5's record revealed:
-Physical therapy notes dated 7/10/15 and 7/28/18 documenting "continues to make progress with functional mobility, and "able to stand with walker, improved ability sit to stand transfer."
-An 8/11/15 physical therapy plan of care recertification noting, "improved balance, safe transfer, and improved lower extremity ability," with a good possibility of meeting those goals.

Interview with Resident #5's prescribing

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D 270	Continued From page 8 practitioner on 11/5/15 at 5:05pm revealed the resident probably needed to be at a higher level of care due to the falls he had sustained. Review of the facility's policy on falls revealed: -Associates received education regarding seniors and falls during their orientation process and annual thereafter. -A risk identification evaluation is completed for each resident upon move-in, upon change of condition, and every six months thereafter. -Residents who have fall risks identified will have individualized interventions included in there personal service plans. -Following a fall, the associates complete the post fall investigation to determine if the resident's fall risks have changed and/or if intervention need to be updated. -Falls are reviewed at the collaborative care review to ensure follow-up. Review of Resident #5's record revealed: -A risk identification evaluation completed on 8/5/15. -The evaluation noted resident had fallen within the past 12 months. _____ On 11/5/15 the facility provided the following plan of protection: -The Health and Wellness Director (HWD) will provide training and or retraining to associates on fall management and prevention within 14 days. -Residents identified as fall risks will be assessed for immediate interventions. -The HWD will follow-up on all falls to ensure preventative measures are being taken to reduce recurring falls. -Additional training will be provided to associates as needed.	D 270		

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D 270	Continued From page 9 THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 6, 2015.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to notify the Primary Care Provider of refusal of Lasix for 1 of 5 (Resident #2) sampled residents. The findings are: Review of Resident #2's current FL2 dated 10/12/15 revealed: -Diagnoses of congestive heart failure, history of aortic valve stenosis with valve replacement, pulmonary hypertension, coronary artery disease, chronic obstructive pulmonary disease (COPD), and chronic kidney disease. -An admission date of 9/03/09. -A medication order for Lasix (a medication used to treat edema related to congestive heart failure) 40mg twice daily. Review of Resident #2's Medication Administration Record (MAR) for August 2015 revealed:	D 273		

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-Lasix 40mg twice daily at 8:00am and 2:00pm.
-Lasix was documented as refused by Resident #2 forty-six occurrences out of sixty-two opportunities.
-Documentation was absent regarding notification of the Primary Care Provider (PCP) on the MAR.

Review of Resident #2's MAR for September 2015 revealed:
-Lasix 40mg twice daily at 8:00am and 2:00pm.
-Lasix was documented as refused by Resident #2 fifty-eight occurrences out of sixty opportunities.
-Documentation was absent regarding notification of the PCP on the MAR.

Review of Resident #2's MAR for October 2015 revealed:
-Lasix 40mg twice daily at 8:00am and 2:00pm.
-Lasix was documented as refused by Resident #2 16 occurrences out of sixty-two opportunities.
-Documentation was absent regarding notification of the PCP on the MAR.

Review of Resident #2's MAR for November 2015 revealed:
-Lasix 40mg twice daily at 8:00am and 2:00pm.
-Lasix was documented as refused by Resident #2 5 occurrences out of nine opportunities from 11/01/15 at 8:00am to 11/05/15 at 8:00am.
-Documentation was absent regarding notification of the PCP on the MAR.

Review of Resident #2's record revealed:
-Documentation was absent regarding notification of the PCP of the resident's refusal of Lasix 40mg twice daily from August 2015 to November 2015.
-A note on the facility's Resident Log sheet dated 10/02/15 that stated, "Resident complains of feeling strange and that things weren't right."

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D 273	Continued From page 11 Review of a recent hospital admission and discharge summary dated 10/12/15 for Resident #2 revealed: -Resident #2 presented to the emergency department with cough and shortness of breath on 10/02/15. -Her symptoms had been going on for 5 days and had become progressively worse. -She was admitted to the hospital with diagnoses of community acquired pneumonia and acute exacerbation of COPD. -Her admission weight was documented as 230 pounds, and after aggressive treatment with oral Lasix her discharge weight was documented at 203 pounds. Interview with Resident #2 on 11/03/15 at 9:00am revealed: -She was recently admitted to the hospital and they "took 20 pounds of fluid off me". -"I went in weighing 223 pounds and left at 203 pounds." Observation of Resident #2's lower extremities on 11/03/15 at 9:00am revealed: -One to two plus pitting edema (swelling) in bilateral lower extremities. -A small weeping wound covered by a gauze dressing on left medial lower leg. Interview with Resident #2 on 11/5/15 at 4:00pm revealed: -She was weighed at the PCP's office today at 209 pounds. -She had been refusing the Lasix when she had PCP appointments, and other times because she didn't want to ask staff to help her with toileting due to her leg pain.	D 273		

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Interview with a first shift Medication Aide (MA) on 11/5/15 at 11:17am revealed:
-When residents refuse medications 2 or 3 times we notify the PCP via fax and await a response.
-The notification should be documented in the progress notes and new orders would be filed under the physician order tab.
-Weights had not been done on any residents "in a long time" unless there was an order on the MAR.

Interview with the Health and Wellness Director (HWD) on 11/5/15 at 11:30am revealed:
-There was no documentation in Resident #2's record regarding notification of the PCP of the resident's refusal of Lasix from August 2015 to November 2015.
-It is the responsibility of the MAs to document refusal of medications and notification of the PCP in the progress notes section of the record.
-Documentation of weights for 2015 were not available for Resident #2.

Interview with a second shift MA on 11/5/15 at 6:00pm revealed:
-Resident #2 did not want to take her Lasix due to having to ask for help to the bathroom. (Resident #2 had a lower leg fracture in August that limited her mobility)
-"We probably didn't fax the MD on that [refusal of Lasix]."
-Resident #2 had been feeling tired, was congested and short of breath prior to being sent to the hospital on 10/02/15.

Telephone interview with Resident #2's PCP's assistant on 11/5/15 at 1:27pm revealed that the PCP was made aware of the missed doses of Lasix by survey staff and wants to continue with current Lasix order and follow-up with the

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D 273	Continued From page 13 resident in one month. _____ On 11/5/15 the facility provided the following plan of protection: -The HWD, Resident Care Coordinator (RCC), and Executive Director (ED) will inquire daily for one week, weekly for one month, and randomly thereafter, any refusals of medications. -The HWD/RCC/MA will notify the PCP of any refusals, and obtain any further direction from the PCP and document in the resident's chart. -HWD or designee will re-train MAs on medication refusal, documentation and notification policies. -HWD will provide additional training as needed. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 21, 2015.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and	D 276		

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	HAL036012	A. BUILDING: _____ B. WING _____	R 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE UNION	1717 UNION ROAD GASTONIA, NC 28054

(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) COMPLETE DATE
D 276	Continued From page 14 interviews, the facility failed to implement blood pressure monitoring as ordered by their prescribing practitioner for 3 of 5 (#1, #4, and #5) sampled residents. The findings are: A. Review of Resident #1's current FL2 dated 5/20/15 revealed: -Diagnoses of chronic obstructive pulmonary disease, fatigue, hypertension, a history of stroke and deep vein thrombosis, and oxygen dependent. -An admission date of 5/13/15. -A medication order for Verelan (Verapamil) 240mg 1 daily. (Verelan is a medication used to treat hypertension and heart disease.) Review of Resident #1's record revealed: -An order dated 9/14/15 to check resident's blood pressure every morning, and hold Verapamil if blood pressure is less than 120/80. If blood pressure over 150/80, notify MD (Medical Doctor.) -Another order dated 9/21/15 with the same parameters for Verelan. Review of Resident #1's Medication Administration Records (MARs) and attached vital sign sheet for September 2015 revealed: -A handwritten entry to hold Verapamil if reading is less than 120/80. If reading is greater than 150/80 notify DMHC (an abbreviation for the facility's in house medical group.) -Fourteen blood pressures monitored from 9/15/15 through 9/30/15, with no blood pressures documented as monitored on 9/18/15 and 9/19/15. -The blood pressures ranged from 90/57 to 172/71, with Verapamil held correctly 6 times for	D 276		

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D 276	Continued From page 15	D 276		

blood pressures less than 120/80.
-Two blood pressures on 9/16/15 and 9/21/15 were below 120/80 and Verapamil was not documented as held.

Review of Resident #1's Medication Administration Records (MARs) for October 2015 revealed:
-A typewritten entry to check blood pressure daily, hold Verapamil if (BP)blood pressure less than 120/80, call MD if BP greater than 150/80, with a scheduled time of 8am.
-Blood pressures had been initialed as performed daily from 10/1/15 through 10/31/15, but no blood pressures documented on the MAR.
-An entry for Verapamil ER 240mg (Verelan) scheduled for administration at 8am, and documented as administered daily from 10/1/15 through 10/31/15.
-No vital sign sheet was attached to the October MAR.

Interview with the Resident Care Coordinator (RCC) on 11/4/15 at 3:15pm revealed the blood pressures should be documented on the MAR.

Review of Resident #1's Medication Administration Records (MARs) for November 2015 revealed:
-A typewritten entry to check blood pressure daily, hold Verapamil if (BP)blood pressure less than 120/80, call MD if BP greater than 150/80, with a scheduled time of 8am.
-Blood pressures had been initialed as performed daily from 11/1/15 through 11/5/15, with 2 blood pressures documented on the MAR on 11/4/15 of 144/86, and 11/5/15 of 95/57.
-An entry for Verapamil ER 240mg (Verelan) scheduled for administration at 8am, and documented as administered daily from 11/1/15

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D 276	Continued From page 16	D 276		

through 11/5/15.
-No vital sign sheet was attached to the October MAR.

Interview with a Medication Aide (MA) on 11/3/15 at 4:00pm revealed:
-He never checked Resident #1's blood pressure prior to giving his Verapamil.
-He could not explain why he had initialed Resident #1's November MAR on 11/3/15 to indicate he had taken his blood pressure that morning.
-He usually worked at least 3 days a week, but usually from 6pm to 6am.

Per observation, this MA worked first shift all three morning of the survey.

Interview with this same MA on 11/5/15 at 2:45pm revealed:
-He had administered Resident #1's Verapamil on 11/4/15, but did not administer it today due to blood pressure 95/57.
-He had forgotten to circle his initials on 11/5/15 to indicate he had held the Verapamil this morning.

Review of Resident #1's medications on hand on the morning of 11/4/15 revealed:
-A bubble package of Verapamil ER 240mg labeled, 1 tablet daily, hold if blood pressure is less than 120/80.
-The package of Verapamil had been dispensed on 10/7/15 with 30 tablets and 19 remained in the package.

Interview with Resident #1 on 11/3/15 at 4:25pm revealed:
-"They (staff) do not check my blood pressure daily.

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D 276	Continued From page 17 -"They may check it twice a week." -Resident #1 wasn't sure which medications he was currently taking. Interview with a pharmacy technician at the dispensing pharmacy on 11/4/14 at 10:20am revealed: -Resident #1's Verapamil was dispensed on 11/3/15 for 30 tablets, 10/7/15 for 30 tablets, 9/7/15 for 30 tablets, and 8/11/15 for 30 tablets. -The most recent prescription they had for Resident #1's Verapamil contained the parameters, hold for blood pressure less than 120/80. Interview with staff at the prescribing practitioner's office on 11/4/15 at 10:42am revealed she ordered the parameters for Resident #1's Verapamil because he frequently becomes hypotensive (low blood pressure.) Refer to interview with Resident Care Coordinator (RCC) on 11/4/15 at 3:15pm. B. Review of Resident #5's current FL2 dated 10/14/14 revealed: -Diagnoses that included dementia, congestive heart failure, hypertension, and ischemic heart disease. -An admission date of 8/20/14. Interview with the Resident Care Coordinator (RCC) on 11/5/15 at 9:30am revealed a new FL2 had been completed and was awaiting a signature from the facility's new physician scheduled to come to the facility on 11/6/15. Review of the new unsigned and undated FL2 and a signed physician's order sheet dated 1/14/15 revealed:	D 276		

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D 276	Continued From page 18 -An order for blood pressures to be checked three times a week on Monday, Wednesday, and Friday. - Medication orders for Lasix 40mg daily, Imdur 60mg once daily, Coreg 12.5mg twice daily, Hydralazine 50mg twice daily, Lisinopril 20mg twice daily, and Aldactone 25mg once daily. (All these medications are used to treat hypertension and heart failure.) Review of Resident #5's record revealed: -A subsequent order changed the Lisinopril to 40mg daily. -A subsequent order changed the Hydralazine to 50mg three times a day. Review of Resident #5's Medication Administration Records (MARs) for September 2015 revealed: - A type written entry for blood pressures three times a week on Monday, Wednesday, and Friday. -The blood pressures had been initialed as taken three times a week. -The blood pressures were documented on an attached vital sign sheet and ranged from 173/91 to 220/114. -Only 7 blood pressures, on 9/2, 9/4, 9/14, 9/16, 9/18, 9/21, and 9/25, were documented on the vital sign sheet. (13 blood pressures were required during September 2015 to have blood pressures performed every Monday, Wednesday, and Friday.) Review of Resident #5's Medication Administration Records (MARs) for October 2015 revealed: - A type written entry for blood pressures three times a week on Monday, Wednesday, and Friday.	D 276		

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-The blood pressures had been initialed as taken three times a week.
-The blood pressures were documented on an attached vital sign sheet and ranged from 129/66 to 204/117.
-Only 8 blood pressures, on 10/2, 10/5, 10/7, 10/12, 10/14, 10/16, 10/23, and 10/28, were documented on the vital sign sheet. (13 blood pressures were required during October 2015 to have blood pressures performed every Monday, Wednesday, and Friday.)

Review of Resident #5's Medication Administration Records (MARs) for November 2015 revealed:
- A type written entry for blood pressures three times a week on Monday, Wednesday, and Friday.
-Two blood pressures had been initialed as taken on 11/3 and 11/4 of 172/88 and 201/115 respectively.

Review of facility faxes dated 3/9/15 through 10/21/15 to the prescribing practitioner revealed she was aware of Resident #5's blood pressures.

Interview with the Health and Wellness Director on 11/5/15 at 8:05am revealed she could not find any other documentation of blood pressures being performed on Resident #5, and could not explain why they were not done.

Refer to interview with Resident Care Coordinator (RCC) on 11/4/15 at 3:15pm.

C. Review of Resident #4's current FL2 dated 8/31/15 revealed:
-Diagnoses of sick sinus syndrome, congestive heart failure, hypertension, coronary artery disease, atrial fibrillation, and chronic kidney

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D 276	Continued From page 20	D 276		

disease.
-An admission date of 06/14/12.
-A medication order for Imdur (a vasodilator medication used to treat chest pain) 30mg daily, Coreg (a medication used to treat hypertension and congestive heart failure) 6.25mg twice daily, Norvasc (a medication used to treat hypertension and coronary artery disease) 10mg daily, Hydralazine (a medication used to treat congestive heart failure and moderate to severe hypertension) 100mg three times daily, and Cozaar (a medication used to treat hypertension) 50mg twice daily.

Review of Resident #4's record revealed:
-An order dated 9/02/15 to hold resident's blood pressure (BP) medications for that day.
-An order dated 9/11/15 to hold BP medications if blood pressure is less than 100/70 or less.
-An order dated 9/14/15 to stop Hydralazine.

Review of Resident #4's Medication Administration Record (MAR) and attached vital sign sheet for September 2015 revealed:
-Imdur 30mg daily at 8:00am, check BP prior to giving.
-Norvasc 10mg daily at 8:00am, check BP prior to giving.
-Coreg 6.25mg twice daily at 8:00am and 5:00pm, check BP prior to giving.
-Cozaar 50mg twice daily at 8:00am and 8:00pm, check BP prior to giving.
-Hydralazine 100mg three times daily at 8:00am, 2:00pm, and 8:00pm, hold for systolic BP less than 120. (This medication was discontinued on 9/11/15)
-A handwritten entry on the MAR to hold all BP medications if blood pressure reading is 100/70 or less.
-An entry on the MAR to check blood pressure

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D 276	Continued From page 21	D 276		

every day with a stop date of 9/10/15.
-A handwritten entry on the vital sign sheet with an origination date of 9/1/15 to manually check blood pressures prior to administration of all blood pressure medications.
-A typewritten entry on the vital sign sheet with an origination date of 9/10/15 to notify physician if systolic reading is greater than 180 and/or diastolic is greater than 100.
-Fifteen blood pressure readings were not documented on the vital sign sheet from 9/01/15 through 9/30/15.
-Blood pressures ranged from 78/38 to 179/70 for September 2015.

Review of Resident #4's MAR and attached vital sign sheet for October 2015 revealed:
-Imdur 30mg daily at 8:00am.
-Norvasc 10mg daily at 8:00am.
-Coreg 6.25mg twice daily at 8:00am and 5:00pm.
-Cozaar 50mg twice daily at 8:00am and 8:00pm.
-An entry on the MAR to notify physician if systolic BP reading is greater than 180 and/or diastolic is greater than 100.
-An entry on the MAR to check blood pressure every day at 8:00am prior to medication administration with a manual cuff.
A typewritten order to check and record blood pressure prior to administration of Imdur, Coreg, Norvasc and Cozaar.
-Twenty blood pressure readings were not documented on the vital sign sheet from 10/13/15 through 10/31/15.
-Blood pressures ranged from 95/55 to 197/75 for October 2015.

Review of Resident #4's MAR and attached vital sign sheet for November 2015 revealed:
-Imdur 30mg daily at 8:00am.

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-Norvasc 10mg daily at 8:00am.
-Coreg 6.25mg twice daily at 8:00am and 5:00pm.
-Cozaar 50mg twice daily at 8:00am and 8:00pm.
-An entry on the MAR to notify physician if systolic BP reading is greater than 180 and/or diastolic BP is greater than 100.
-An entry on the MAR to check blood pressure every day at 8:00am prior to medication administration with a manual cuff.
-The vital sign sheet did not specify when to perform blood pressure checks each day.
-There were eight blood pressure readings documented from 11/01/15 to 11/05/15.
-Five blood pressure readings were not documented on the vital sign sheet from 11/01/15 through 11/05/15.

Further review of the Resident #4's record revealed there was no order to discontinue blood pressure checks at 8:00am, 5:00pm, and 8:00pm prior to the administration of blood pressure medications.

Confidential interview with a Medication Aide (MA) revealed:
-The MA only checked Resident #4's blood pressure prior to the administration of the 8:00am blood pressure medications.
-The MA was following the orders on the November MAR, which only had a BP check due at 8:00am.

Interview with the Health and Wellness Director (HWD) on 11/5/15 at 9:00am revealed:
-She could not find any other documentation of blood pressures being performed on Resident #4, and could not explain why they were not done.
-Vital signs were to be done monthly per facility policy, unless otherwise ordered by the Primary

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D 276	Continued From page 23 Care Provider (PCP). Interview with Resident #4's PCP was unsuccessful by exit. Refer to interview with Resident Care Coordinator (RCC) on 11/4/15 at 3:15pm. Refer to facility's policy on Medication and Treatment. --- Interview with the Resident Care Coordinator (RCC) on 11/4/15 at 3:15pm revealed the blood pressures should be documented on the MAR. Review of the facility's policy on Medication and Treatment revealed medication assistance and administration must be in accordance with the prescriber's orders. _____ On 11/5/15 the facility provided the following plan of protection: -The HWD/RCC/ED will observe medication passes daily for one week, weekly for one month, and random observations after one month. -The HWD/RCC will audit MARs to verify medication administration is being done correctly. -The HWD/RCC will audit MARs to make certain that blood pressures, pulse and/or medications tied to a parameter are given a space to record directly on the MAR instead of a separate vital sign sheet. -HWD will provide re-training and additional training as needed to medication aides. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED	D 276		

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D 276	Continued From page 24 DECEMBER 21, 2015.	D 276		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to tuberculosis testing, personal care and supervision, health care referral and follow-up, and health care implementation. The findings are: 1. Based on record reviews and interviews, the facility failed to assure 2 of 5 sampled residents (#1 and #5) were tested for tuberculosis (TB) disease on admission in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. [Refer to Tag 234, 10A NCAC 13F .0703(a) Tuberculosis test, Medical Examination and Immunizations (Type B Violation.)] 2. Based on observations, record reviews, and interviews, the facility failed to assure adequate supervision for 1 of 3 (#5) sampled residents with	D912		

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D912	Continued From page 25 falls. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation.)] 3. Based on observations, record reviews, and interviews, the facility failed to notify the Primary Care Provider of refusal of Lasix for 1 of 5 (Resident #2) sampled residents. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation.)] 4. Based on observations, record reviews, and interviews, the facility failed to implement blood pressure monitoring as ordered by their prescribing practitioner for 3 of 5 (#1, #4, and #5) sampled residents. [Refer to Tag 276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation.)]	D912		