Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL090024 | A. BUILDING: _____ B. WING _____ | 02/22/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BROOKDALE MONROE SQUARE 1 | 918 FITZGERALD STREET MONROE, NC 28112 |

| (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 |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on February 18-19, 2016 with an exit conference via telephone on February 22, 2016. | D 000 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to assure physician notification for 1 of 5 sampled residents (Resident #3) for refusal of dental paste.<br><br>The findings are:<br><br>Review of Resident #3's current FL-2 dated 05/06/15 revealed:<br>-Diagnoses included hypertension, hyperlipidemia, depression and osteoporosis.<br>-A physician's order for Denta 5000 Plus 1.1% use at bedtime. (Denta 5000 Plus is a fluoride supplement used to treat dental caries).<br><br>Review of Resident #3's record revealed signed physician orders dated 01/12/16 prescribing Denta 5000 Plus 1.1% use at bedtime.<br><br>Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 09/06/09.<br><br>Review of Resident #3's Medication | D 273 | See Attached Plan of Correction | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Amie James TITLE Executive Director (X6) DATE 3/16/2016

STATE FORM 6899 8G0G11 If continuation sheet 1 of 25

Reviewed and Accepted
3/18/2016 tw

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| D 273 | Continued From page 1<br><br>Administration Records (MARs) for December 2015, January 2016, and February 2016 revealed:<br>-Denta 5000 Plus 1.1% use as directed at bedtime was listed on the MARs and scheduled for administration at 8:00 pm.<br>-Denta 5000 Plus 1.1% was documented as refused daily from 12/01/15 to 02/17/16. (Medication refusal was documented by medication aide's initials circled on the front of the MAR and "refused" written on the back of the MAR.<br><br>Observation of the medication on hand for administration to Resident #3 on 02/19/16 at 4:50 pm revealed:<br>-One 51 gm tube of Denta 5000 Plus 1.1% label with a dispensing date of 03/11/15 was located on the medication cart.<br>-The seal was broken but the tube appeared almost full.<br><br>Interview on 2/19/16 at 9:50 am with the Health and Wellness Director (HWD) revealed:<br>-She was a Registered Nurse.<br>-The facility routinely had a Resident Care Coordinator (RCC) on staff to monitor medication administration.<br>-The RCC no longer worked at the facility. She left in the previous two weeks.<br><br>Second interview on 02/19/16 at 5:00 pm with the HWD revealed:<br>-The previous RCC would routinely be responsible for checking the MARs for completeness and monitoring for residents refusing medications.<br>-The previous RCC was responsible to notify prescribers for medication refusals.<br>-The HWD had assumed many of the | D 273 | | |

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| D 273 | Continued From page 2<br><br>responsibilities of the previous RCC since her departure.<br>-No Medication Aide staff had informed her Resident #3 had been refusing to use Denta 5000 Plus dental paste, therefore she had not notified the resident's prescriber (Dentist).<br><br>Interview on 02/19/16 at 4:40 pm with a Medication Aide (MA) on evening shift revealed:<br>-She routinely worked the evening shift and alternated medication carts on which she was assigned.<br>-She was assigned the medication cart, on an alternating basis, that stored Resident #3's medications, including Denta 5000 Plus.<br>-Resident #3 had refused the Denta 5000 dental paste every night for several months when she worked the resident's medication cart.<br>-The day shift MAs would be responsible for notifying physicians for medication refusals because the physicians' offices were routinely closed during most of her shift.<br>-She documented the resident's refusal of Denta 5000 Plus on the MAR, but she had not informed the facility Nurse that Resident #3 was refusing her dental paste.<br>-She had not notified Resident #3's Dentist that the resident was refusing Denta 5000 Plus at bedtime.<br><br>Interview on 02/19/16 at 5:15 pm with second evening shift MA revealed:<br>-She routinely worked evening shifts on every other weekend (Friday, Saturday, and Sunday).<br>-Resident #3 refused Denta 5000 Plus every time she had tried to administer the medication.<br>-She thought the regular day shift MAs would be responsible to notify a resident's physician if the resident was refusing a medication.<br>-She had not notified the resident's physician. | D 273 | | |

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| D 273 | Continued From page 3<br><br>Interview on 2/19/16 at 6:15 pm with Resident #3 revealed:<br>-She was aware she was ordered the dental paste for brushing her teeth.<br>-The Denta 5000 Plus was originally ordered by her Dentist when she was having dental pain with a back tooth.<br>-She was not experiencing pain with the tooth anymore so she stopped using the dental paste.<br>-She did not know if her Dentist was aware she was refusing to use the dental paste.<br><br>Interview on 02/19/16 at 6:40 pm with the Executive Director revealed:<br>-The staff should notify a physician any time a resident refused or did not receive medications and/or treatments 3 times in a row.<br>-The previous RCC was responsible for assuring physicians were notified of refusals.<br>-The facility did not currently have a RCC.<br>-The HWD had agreed to be responsible for monitoring medication administration until a new RCC was hired.<br><br>Telephone interview on 02/19/16 at 9:40 am with the contract pharmacy provider revealed:<br>-The facility would be responsible to reorder Resident #3's Denta 5000 Plus when it was needed.<br>-The pharmacy dispensed one 51 gram tube of Denta 5000 Plus for Resident #3 on 03/11/15.<br>-The pharmacy had no further documentation for dispensing Resident #3's Denta 5000 Plus.<br><br>Telephone interview on 02/22/16 at 10:30 am with a representative at Resident #3's Dentist's office revealed:<br>-The dentist's office had no documentation of notification by the facility that Resident #3 was | D 273 | | |

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| D 273 | Continued From page 4<br>refusing to use Denta 5000 Plus each night as prescribed. | D 273 | | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders<br>(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:<br>(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record review, the facility failed to assure clarification of physician's orders for 1 of 5 sampled residents (#5) resulting in the discontinuation of two medications (Klor-Con and Pravastatin).<br><br>The findings are:<br><br>Review of Resident #5's current FL-2 dated 3/20/15 revealed:<br>-Diagnoses included Atrial Fibrillation with a permanent pacemaker insertion, congestive heart failure (CHF), dyslipidemia, and hypothyroidism.<br>-Medications ordered included Klor-Con M 20 mEq daily (used to prevent or treat low potassium levels), and Pravastatin 40 mg at bedtime (used | D 344 | | |

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| D 344 | Continued From page 5<br>to treat high cholesterol and triglyceride levels).<br><br>Review of Resident #5's record revealed:<br>-Computer printed physician's orders signed and dated on 7/15/15 for Klor-Con M 20 mEq daily and Pravastatin 40 mg at bedtime.<br>-These orders were verified by the Resident Care Coordinator (RCC) on 6/28/15.<br><br>Review of Resident #5's November 2015 Medication Administration Record (MAR) revealed:<br>-An entry for Klor-Con 20 mEq daily and scheduled for administration at 8:00 am daily.<br>-Documentation of administration at 8:00 am from 11/1/15 to 11/30/15.<br>-The last dose of Klor-Con was documented as administered on 11/30/15 at 8:00 am.<br>- An entry for Pravastatin 40 mg at bedtime and scheduled for administration at 8:00 pm daily.<br>-Documentation of administration at 8 pm from 11/1/15 to 11/30/15.<br>-The last dose of Pravastatin was documented as administered on 11/30/15 at 8:00 pm.<br>-The "complete entries checked" box of the MAR was signed by the previous RCC on 10/27/15.<br><br>Review of Resident #5's December 2015 MAR revealed:<br>-Klor-Con was not listed on the MAR.<br>-Pravastatin was not listed on the MAR.<br>-The "complete entries checked" box of the MAR was signed by the previous RCC on 11/24/15.<br><br>Review of Resident #5's record revealed:<br>-No physician's order to discontinue Klor-Con or Pravastatin.<br>-A copy of a faxed order from Resident #5's physician signed and dated 10/30/15 listing "Active medications documented" that included | D 344 | | |

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| D 344 | Continued From page 6<br><br>"Pravastatin 40 mg daily for cholesterol, and potassium chloride 20 mEq twice a day".<br>-A pharmacy review was completed on 12/28/16. No recommendations were documented.<br><br>Review of Resident #5's computer printed physician's orders dated 1/05/16 revealed:<br>-The "complete entries checked" box was signed by the Health and Wellness Director (HWD) on 12/28/16.<br>-There was a handwritten entry notation that Resident #5's care was changed to an in-house physician group and signed by the Nurse Practitioner (NP).<br>-The orders were signed and dated by the NP on 1/05/16.<br>-There were no order entries for Klor-Con or Pravastatin, and no discontinuation notations.<br><br>Review of Resident #5's January 2016 MAR revealed:<br>-Klor-Con was not listed on the MAR.<br>-Pravastatin was not listed on the MAR.<br>-The "complete entries checked" box of the MAR was signed by the HWD on 12/28/15.<br><br>Review of Resident #5's February 2016 MAR revealed:<br>-Klor-Con was not listed on the MAR.<br>-Pravastatin was not listed on the MAR.<br>-The "complete entries checked" box of the MAR was signed by the previous RCC on 1/27/16.<br><br>Interview on 2/19/16 at 9:15 am with the facility's contract pharmacy representative revealed:<br>-She did not know why Klor-Con and Pravastatin were omitted from the December 2015 and January MARs.<br>-She did not know why Klor-Con and Pravastatin were omitted from the January pharmacy | D 344 | | |

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| D 344 | Continued From page 7<br>generated physician orders.<br>-There was an email dated 10/30/15 of active medications and Klor-Con and Pravastatin were on it. "It was an error that it dropped off".<br>-"Another pharmacy was handling entering (Resident #5's) orders at that time."<br>-She did not see a discontinue order for Klor-Con or Pravastatin in the system.<br><br>Interview on 2/19/16 at 9:10 am with a Medication Aide (MA) revealed that the "nurses (HWD or previous RCC) were responsible to compare the new MARs to the old MARs and verify them" as correct.<br><br>Interview on 2/19/16 at 9:45 am with a MA revealed:<br>-The process for handling orders was the MAs faxed the orders received to the pharmacy and documented on the MAR and resident record.<br>-The new MARs were verified as correct by the HWD or the previous RCC.<br>-There was a tracking log for any orders that came in after the printed copies of the MARs were printed and when the new MARs started at the first of the month.<br>-Resident #5 had changed physicians three times recently and was now cared for by the in-facility physician's group since December 2015 as requested by the family.<br><br>Interview on 2/19/16 at 9:50 am with the HWD revealed:<br>-She was a Registered Nurse.<br>-The previous RCC no longer worked at the facility. She had left in the previous two weeks.<br>-The previous RCC or the HWD was responsible for checking the MARs month to month for accuracy, which included entering new orders onto the new MAR. | D 344 | | |

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| D 344 | Continued From page 8<br><br>-She was not aware there was no order in the record to discontinue Pravastatin and Klor-Con, and was not aware Resident #5 had not received those medications since 11/30/15.<br>-Resident #5 had changed physicians several times in the past few months, and since 12/01/2015 had been cared for by the in-facility physician's NP.<br>-She was not aware how the NP reviewed the record for orders when she took over the care of Resident #5, but "she had access to the whole chart".<br>-She was not sure when labs were last checked on Resident #5 as the physicians' offices did not always send lab results to be kept in the facility records.<br><br>Interview on 2/19/16 at 10:25 am with the Resident #5's current physician's representative revealed:<br>-Their physician's group took over care of Resident #5 on 12/01/15 and was seen by the NP who no longer works for their group. A second NP now covered this facility, and took over in the middle of January 2016.<br>-There was not an order for Klor-Con or Pravastatin entered in their system.<br>-No labs had been ordered by the NP for Resident #5.<br><br>Interview on 2/19/16 at 2:10 pm with Resident #5's NP revealed:<br>-She took over the resident's care mid January 2016 and had only seen the resident once.<br>-The NP who initially took over care no longer worked with their physician's group.<br>-She was not aware if the previous NP was aware that Klor-Con and Pravastatin were not continued from December 2015.<br>-She was not aware if the facility's staff had | D 344 | | |

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| D 344 | Continued From page 9<br><br>contacted the NP to clarify the orders when Klor-Con and Pravastatin were omitted from the December 2015 MAR.<br>-She was concerned that Klor-Con and Pravastatin had not been given since 11/30/15 since the resident was currently on Lasix (a diuretic used to treat CHF) and no labs were done.<br>-She would not want to start any meds (or stop the Lasix) without seeing the resident first.<br>-She would "be back in the facility on 2/23/16 and would review the record and probably order labs".<br><br>Interview on 2/19/16 at 2:45 pm with Resident #5 revealed:<br>-She took the medications the facility administered to her.<br>-She could not name all the medications she was on.<br>-The facility gave her the medications the physician wanted her to have.<br>-Either she or the facility talked to her physician about her treatment needs.<br><br>Interview on 2/19/16 at 4:00 pm with the Executive Director revealed she expected staff to give medications as ordered and clarify orders as necessary.<br><br>Interview on 2/19/16 at 4:30 pm with the facility's contract pharmacist reviewer revealed:<br>-He looked at the MARs, recent and current orders when he performed pharmacy reviews of a residents' records "to see if there were any interactions or duplications and makes recommendations". "It is a snapshot of what is current". "Sometimes facilities are late with getting paper MARs to the record" so he would have more orders to review.<br>-"No way an order just disappears", "sometimes | D 344 | | |

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| D 344 | Continued From page 10<br>orders get lost".<br>-He "would not necessarily catch a med dropped from one MAR to the next since I only look at the latest MAR on the record". | D 344 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 5 sampled residents (#1, #3, and #5) related to errors with medications for pain, high cholesterol, and low potassium.<br><br>The findings are:<br><br>A. Review of Resident #3's current FL-2 dated 05/06/15 revealed:<br>-Diagnoses included hypertension, hyperlipidemia, depression, symptoms post open reduction internal fixation (ORIF) left ankle and osteoporosis.<br>-A medication order for tramadol 50 mg one tablet | D 358 | | |

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| D 358 | Continued From page 11<br>4 times a day. (Tramadol 50 mg is a narcotic-like pain reliever used to treat moderate to severe pain.)<br><br>Review of Resident #3's "Resident Register" revealed the resident was admitted to the facility on 09/06/09.<br><br>Review of Resident #3's record revealed:<br>-Subsequent physicians' orders dated 09/24/15 and 01/12/16 prescribing tramadol 50 mg every 4 hours as needed for pain.<br>-A physician's order dated 12/14/15 prescribing Morphine Sulfate Extended Release 15 mg (a narcotic pain reliever used to treat severe pain) one tablet every 12 hours.<br>-A physician's order dated 01/04/16 prescribing Morphine Sulfate Extended Release (ER) 15 mg (a narcotic pain reliever used to treat severe pain) one tablet every 8 hours.<br>-A physician's order dated 02/08/16 prescribing tramadol 50 mg one tablet every 8 hours as needed for pain (Instructions: every 8 hours in between morphine).<br>-A physician's order dated 02/16/16 prescribing tramadol 50 mg one tablet every 8 hours as needed for pain (Instructions: every 8 hours in between morphine) with notation to fill after 03/09/16.<br><br>Review of Resident #3's February 2016 Medication Administration Record (MAR) revealed:<br>-Morphine Sulfate ER 15 mg was preprinted on the MAR and scheduled for administration at 9:00 am, 5:00 pm, and 1:00 am.<br>-Tramadol 50 mg one tablet every 4 hours was preprinted on the MAR with documentation for administration from 02/01/16 to 02/16/16.<br>-There was no transcription for tramadol 50 mg | D 358 | | |

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| BROOKDALE MONROE SQUARE 1 | 918 FITZGERALD STREET MONROE, NC 28112 |

| (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 |
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| D 358 | Continued From page 12<br><br>one every 8 hours as needed, as ordered on 02/08/16.<br>-Documentation to discontinue tramadol 50 mg one tablet every 4 hours as needed due to "order change" was handwritten on 02/16/16.<br>-A handwritten order was transcribed on the MAR for tramadol 50 mg one tablet every 8 hours for pain beginning 02/16/16, and was scheduled at 8:00 am, 2:00 pm and 8:00 pm. (The order should have been for as needed, not scheduled.)<br>- An additional handwritten order was transcribed on the MAR beginning 02/16/16 for tramadol 50 mg one tablet as needed (prn) for pain with no dosing parameters.<br><br>Review of Resident #3's February 2016 MAR and "Controlled Medication Utilization Record (CMUR)" revealed documentation that tramadol 50 mg was administered more often than every 8 hours as needed per current orders dated 02/08/16 and 02/16/16.<br><br>Review of the CMURs generated by the pharmacy and used to track administration of tramadol 50 mg, one tablet every 4 hours as needed for pain, for Resident #3 revealed:<br>-Thirty tramadol 50 mg were dispensed 01/18/16, 01/23/16, and 02/02/16 with documentation for administration, per resident request, routinely at 12:00 midnight, 10:00 am, 2:00 pm, and 8:00 pm daily from 01/19/16 to 02/09/16.<br><br>Review of additional CMURs for Resident #3's tramadol revealed 90 tablets dispensed on 02/10/16 (orderds 02/08/16) with instructions for one tablet every 8 hours as needed for pain, and administration documented as follows:<br>-On 02/11/16- one tablet at 12:00 am, 10:00 am, 2:00 pm, and 8:00 pm.<br>-On 02/12/16- one tablet at 12:00 am, 10:00 am, | D 358 | | |

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| D 358 | Continued From page 13<br>2:00 pm, and 8:00 pm.<br>-On 02/13/16- one tablet at 12:00 am, 10:00 am, 2:00 pm, and 8:00 pm.<br>-On 02/15/16- one tablet at 12:00 am, 10:00 am, 2:00 pm, and 8:00 pm.<br>-On 02/16/16- one tablet at 12:00 am, 10:00 am, 2:00 pm, and 8:00 pm.<br>-On 02/17/16- one tablet at 12:00 am, 10:00 am, 2:00 pm, and 8:00 pm.<br>-On 02/18/16- one tablet at 12:00 am, 10:00 am, 2:00 pm, and 8:00 pm.<br><br>Telephone interview on 02/19/16 at 4:45 pm with a representative for the contract pharmacy revealed:<br>-The pharmacy the current order for Resident #3's was tramadol 50 mg one tablet every 8 hours, as needed for pain dated 02/08/16.<br>-The pharmacy dispensed 90 tramadol 50 mg on 01/16/16.<br>-The pharmacy dispensed 90 tramadol 50 mg tablets on 2/10/16.<br>-The pharmacy had an order for Resident #3's tramadol 50 mg one tablet every 8 hours, as needed for pain dated 02/16/16 on file for dispensing after 03/09/16 as ordered.<br><br>Interview on 02/19/16 at 5:30 pm with an evening shift Medication Aide (MA) revealed:<br>-The MA on duty when a physician's order was received was responsible to fax a copy of the order to the pharmacy, transcribe the order to the MAR.<br>-The previous RCC was responsible to review the order, including transcription on the MAR, for accuracy.<br>-She thought the HWD was responsible to check behind the MAs until the RCC was replaced.<br><br>Interview on 02/19/16 at 5:45 pm with the Health | D 358 | | |

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| D 358 | Continued From page 14<br>and Wellness Director (HWD) revealed:<br>-She was a Registered Nurse.<br>-The RCC had left the facility unexpectedly one week ago.<br>-The HWD had assumed many of the responsibilities of the previous RCC including reviewing new orders transcribed on residents' MARs.<br>-She had discovered the previous RCC was not current on reviewing physician's orders entered by MA staff on residents' MARs.<br>-The HWD had not reviewed all the current orders transcribed on residents' MARs.<br>-She was not aware Resident #3's tramadol 50 mg was not being administered as ordered.<br><br>Review of the facility "New Order Tracking log" revealed Resident #3's order dated 02/08/16 for tramadol 50 mg one tablet every 8 hours, as needed for pain, was entered on the tracking log but not checked off as having been reviewed by the previous RCC or HWD.<br><br>Interview on 02/19/16 at 6:15 pm with Resident #3 revealed:<br>-She had recent changes to her pain medications.<br>-The pain clinic she was now attending had been working with her to get better pain control.<br>-She was aware she had tramadol 50 mg "as needed" ordered by the physician.<br>-She was not aware of how often the physician had ordered the medication could be taken.<br><br>Interview on 02/19/16 at 6:30 pm with the Executive Director revealed:<br>-The previous RCC had been gone for about one week.<br>-The HWD had assumed many of the responsibilities of the previous RCC.<br>-The HWD was responsible for assuring the MA | D 358 | | |

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| D 358 | Continued From page 15<br>staff were administering medications as ordered.<br><br>Observation of medication on hand for administration for Resident #3 on 02/19/16 revealed 56 tramadol 50 mg tablets remaining of 90 tablets dispensed on 2/10/16.<br><br>B. Review of Resident #5's current FL2 dated 3/20/15 revealed:<br>-Diagnoses included atrial fibrillation with a permanent pacemaker inserted, congestive heart failure (CHF), dyslipidemia, hypothyroidism, macular degeneration, osteoporosis, and osteoarthritis.<br>-Medication orders for Klor-Con M 20 mEq daily (used to prevent or treat low potassium levels), and Pravastatin 40 mg at bedtime (used to treat low cholesterol and triglyceride levels).<br><br>Review of Resident #5's Resident Register revealed an admission date of 3/12/14.<br><br>Review of Resident #5's November 2015 Medication Administration Record (MAR) revealed:<br>-An entry for Klor-Con 20 mEq daily was documented as administered at 8:00 am from 11/01/15 to 11/30/15.<br>-The last dose of Klor-Con was documented as administered on 11/30/15 at 8:00 am.<br>-An entry for Pravastatin 40 mg at bedtime was documented as administered at 8:00 pm from 11/01/15 to 11/30/15.<br>-The last dose of Pravastatin was documented as administered on 11/30/15 at 8:00 pm.<br><br>Review of Resident #5's December 2015 MAR revealed:<br>-Klor-Con was not listed on the MAR, and no discontinuation notations were documented. | D 358 | | |

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| D 358 | Continued From page 16<br>-Pravastatin was not listed on the MAR, and no discontinuation notations were documented.<br><br>Review of Resident #5's record revealed:<br>-Computer printed physician's orders signed and dated on 7/15/15 that continued Lasix 40 mg daily, Klor-Con 20 mEq daily and Pravastatin 40 mg at bedtime.<br>-A faxed copy of orders from Resident #5's physician signed and dated 10/30/15 listing "Active medications documented" that included "Pravastatin 40 mg daily for cholesterol, and potassium chloride 20 mEq twice a day".<br>-No physician's order to discontinue Klor-Con or Pravastatin.<br>-A pharmacy review was completed on 12/28/15. No recommendations were documented.<br><br>Review of the computer printed physician's orders dated 1/05/16 revealed:<br>-There was a handwritten entry notation that Resident #5's care was changed to an in-house physician group, and signed by the Nurse Practitioner (NP).<br>-The orders were signed and dated by the NP on 1/05/16.<br>-There were no order entries for Klor-Con or Pravastatin, and no discontinuation notations.<br><br>Review of Resident #5's January 2016 MAR revealed:<br>-Klor-Con 20 mEq was not listed on the MAR.<br>-Pravastatin 40 mg was not listed on the MAR.<br><br>Interview on 2/19/16 at 9:15 am with the facility's contract pharmacy representative revealed:<br>-She did not know why Klor-Con and Pravastatin were omitted from the December 2015 and January 2016 MARs.<br>-She did not know why Klor-Con and Pravastatin | D 358 | | |

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| D 358 | Continued From page 17<br>were omitted from the January pharmacy generated physician orders signed 1/05/16.<br>-There was an email dated 10/30/15 of active medications and Klor-Con and Pravastatin were on it. "It was an error that it dropped off".<br>-"Another pharmacy was handling entering (Resident #5's) orders at that time." (It was noted that the same pharmacy name appeared on all MARs in Resident #5's record.)<br>-She did not see a discontinue order for Klor-Con or Pravastatin in the system.<br><br>Interview on 2/19/16 at 9:10 am with a Medication Aide (MA) revealed:<br>-The "nurses (HWD or previous RCC) were responsible to compare the new MARs to the old MARs and verify them" as correct.<br>-Medications were administered according to what was listed on the MARs.<br><br>Interview on 2/19/16 at 9:45 am with a MA revealed:<br>-The new MARs were verified as correct by either the HWD or the previous RCC.<br>-Medications were administered according to what was listed on the MARs.<br><br>Interview on 2/19/16 at 9:50 am with the HWD revealed:<br>-She was a Registered Nurse.<br>-The previous RCC no longer worked at the facility. She left in the previous two weeks.<br>-The previous RCC or the HWD was responsible to check the MARs month to month for accuracy, which included entering new orders onto the new MAR.<br>-She was not aware there was no order in the record to discontinue Pravastatin and Klor-Con, and was not aware that Resident #5 had not received those medications since 11/30/15.. | D 358 | | |

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| D 358 | Continued From page 18<br><br>-Resident #5 had changed physicians several times in the past few months, and since 12/01/2015 had been cared for by the in-facility physician's NP.<br><br>Interview on 2/19/16 at 2:10 pm with Resident #5's current NP revealed:<br>-She took over the resident's care mid-January 2016 and had only seen the resident once. The NP who initially took over care no longer works with their physician's group.<br>-She was not aware if the previous NP was aware that Klor-Con and Pravastatin were not continued from December 2015.<br>-She was not aware if the facility's staff had contacted the NP to clarify the orders when Klor-Con and Pravastatin were omitted from the December 2015 MAR.<br>-She was concerned that Klor-Con and Pravastatin had not been given since 11/30/15.<br>-She would not want to start or stop any meds without seeing the resident first. She would "be back in the facility on Tuesday and would review the record and probably order labs".<br><br>Interview on 2/19/16 at 2:45 pm with Resident #5 revealed:<br>-She took the medications the facility administered to her.<br>-She could not name all the medications she was on.<br>-The facility gave her the medications her physician wanted her to have.<br>-Either she or the facility talked to her physician about her treatment needs.<br><br>Interview on 2/19/16 at 4:00 pm with the facility's contract pharmacist reviewer revealed:<br>-He looked at the MARs and recent, current orders when he performed a pharmacy review of | D 358 | | |

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| D 358 | Continued From page 19<br>a resident record "to see if there were any interactions or duplications and makes recommendations". "It is a snapshot of what is current". "Sometimes facilities are late with getting paper MARs to the record" so he would have more orders to review.<br>-"No way an order just disappears", "sometimes orders get lost".<br>-He "would not necessarily catch a med dropped from one MAR to the next since I only look at the latest MAR on the record".<br><br>C. Review of Resident #1's current FL2 dated 11/3/15 revealed:<br>-Diagnoses included hypertension, right hemiparesis, and gout.<br><br>Review of Resident #1's Resident Register revealed an admission date of 11/13/15.<br><br>Review of Resident #1's record revealed:<br>-A physician's order dated 11/19/15 for Tylenol 500 mg twice a day as needed for pain. (Tylenol is used to treat minor aches and pains.)<br>-A copy of a prescription order from an Orthopedic physician dated 11/24/15 for Tramadol 50 mg 1 to 2 tablets every 4 to 6 hours as needed for pain. (Tramadol is a narcotic-like pain reliever used to treat moderate to severe pain.)<br>-A copy of a prescription order from an Orthopedic physician dated 1/05/16 for Tramadol 50 mg 1 to 2 tablets every 4 to 6 hours as needed for pain.<br>-Resident was in the hospital from 12/12/15 to 12/15/15.<br><br>Review of Resident #1's November 2015 Medication Administration Record (MAR) revealed: | D 358 | | |

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| D 358 | Continued From page 20<br>-The MAR was handwritten for the period of 11/13/15 to 11/30/15.<br>-A handwritten entry dated 11/23/15 for Tramadol 50mg 1 tablet every 6 hours prn (as needed) for pain.<br>-Tramadol 50 mg 1 tablet was documented as administered 3 times from 11/26/15 to 11/28/15.<br><br>Review of Resident #1's December 2015 MAR revealed:<br>-There were two sets of handwritten MARs for December. One MAR dated 12/01/15 to 12/12/15, the other MAR dated 12/15/15 to 12/31/15.<br>-An entry for Tramadol 50 mg 1 tablet every 6 hours prn for pain.<br>-Tramadol 50 mg 1 tablet was administered 7 times from 12/01/15 to 12/31/15.<br>-No Tramadol was documented as administered while the resident was in the hospital.<br><br>Review of Resident #1's January 2016 MAR revealed:<br>-An entry for Tramadol 50 mg 1 tablet every 6 hours prn for pain.<br>-Tramadol 50 mg 1 tablet was documented as administered 23 times from 1/06/16 to 1/31/16.<br><br>Review of Resident #1's February 2016 MAR revealed:<br>-An entry for Tramadol 50 mg 1 tablet every 6 hours prn for pain with a handwritten mark through it with "duplicate" notation.<br>-An entry dated 1/05/16 for Tramadol 50 mg 1-2 tablets every 6 hours prn for pain.<br>-Tramadol 50 mg prn was documented as administered 6 times from 02/01/16 to 2/07/16. The last dose was documented as administered 2/07/16 at 12:00 am.<br>-Tramadol 50 mg prn notation on the back of the MAR for 2/09/16 revealed that "med ordered". | D 358 | | |

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| D 358 | Continued From page 21<br><br>Review of Resident #1's January 2016 controlled medication utilization record revealed:<br>-A label dated 1/05/16 for Tramadol 50 mg 1 to 2 tablets every 4 to 6 hours as needed for pain.<br>-Thirty Tramadol 50 mg were dispensed on 1/05/16.<br>-Documentation of administration from 1/06/16 to 2/07/16, leaving no medications remaining; All were signed out by staff appropriately.<br>-The last dose was documented as administered 2/07/16 at 12:00 am.<br><br>Review of medications on hand for administration with the MA on 2/19/16 at 11:20 am revealed:<br>-There was no Tramadol available on the cart for Resident #1.<br><br>Interview with a Medication Aide (MA) on 2/19/16 at 11:20 am revealed:<br>-Tramadol was out of stock, and needed a "hard copy script" from the physician to be filled by the pharmacy.<br>-She had faxed a notice to Resident #1's primary care physician (PCP) last week, but that PCP is "slow to respond".<br>-She would normally wait a few days for a response from the PCP, then fax a request again if no reply, but had not done this for this resident.<br><br>Interview with a second MA on 2/19/16 at 11:35 am revealed:<br>-We were not supposed to wait until a medication was out of stock before contacting the physician for a refill prescription.<br>-If a medication was out of stock, the staff were to send a refill request via fax to the pharmacy.<br>-If it was a medication that required a "hard script", the MA would fax a request to the appropriate physician, and contact that | D 358 | | |

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| D 358 | Continued From page 22<br><br>physician's office by telephone if no reply in 30 minutes for a scheduled medication, but the MA would wait longer if it was a prn medication.<br>-The MA would keep calling until a response from the physician's office.<br>-Faxed requests were kept in a "waiting on physician" notebook in the med room.<br><br>Review of the "waiting on physician" notebook in the med room revealed:<br>-A faxed order dated 2/11/16 and time stamped 2:43 pm, written by a MA, and marked "urgent", "please respond" to Resident #1's PCP about "new hard script for Tramadol needed, he is completely out. Please call when ready."<br><br>Interview on 2/19/16 at 12:30 pm with Resident #1 revealed:<br>-His left arm still ached. He did have pain meds available, but needed Tramadol.<br>-When he asked for a pain med, the facility had been giving him Tylenol.<br>-He had not specifically asked for Tramadol.<br>-He was not aware the facility ran out of his Tramadol and did not have it available at this time.<br><br>Second interview on 2/19/16 at 2:30 pm with a MA revealed:<br>-All MAs were to follow-up on faxed orders to physicians.<br>-She did not follow up on the fax she sent to the physician the previous week, and had not noticed that Resident #5 still did not have any Tramadol available. "He had not asked me for any, so I did not notice he was out".<br>-She had not realized until today that Resident #1's PCP was not ordering his pain medications, but his orthopedic physician was ordering his pain meds. | D 358 | | |

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| D 358 | Continued From page 23<br>-She had requested an oncoming MA just now to contact the appropriate physician for a Tramadol "hard script".<br>-She was not aware that the resident had been out of Tramadol for 8 days.<br><br>Interview on 2/19/16 at 3:30 pm with the Health and Wellness Director (HWD) revealed:<br>-She was an RN.<br>-The previous RCC was responsible to check the "waiting on physician" book to follow-up on Resident medication needs.<br>-The previous RCC no longer works at the facility, but left in the previous two weeks.<br>-She was not aware no one was following up on the faxed requests resulting in residents missing medications.<br>-She would have the night shift start checking the log book so resident needs would be met.<br><br>Interview on 2/19/16 at 4:00 pm with the Executive Director revealed that she expected staff to give medications as ordered.<br><br>On 2/19/16, the Executive Director submitted a Plan of Protection as follows:<br>-The facility would immediately "review resident records to ensure medications are being administered as ordered and any discrepancy, doctor will be notified".<br>-The staff will be in-serviced for the facility's policy regarding medication administration.<br>-The HWD, ED, or designee will be responsible for monitoring record reviews.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 7, 2016. | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL000024 | A. BUILDING: _____ B. WING _____ | 02/22/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE MONROE SQUARE 1 | 918 FITZGERALD STREET MONROE, NC 28112 |

| (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 |
|---|---|---|---|---|
| D912 | Continued From page 24 | D912 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration.<br><br>The findings are:<br><br>Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 5 sampled residents (#1, #3, and #5) related to errors with medications for pain, high cholesterol, and low potassium. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).] | D912 | | |

**Plan of Correction**

**Monroe Square Assisted Living**

**The following is the Plan of Correction for Monroe Square Assisted Living regarding the Statement of Deficiencies dated February 18-19, 2016. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.**

**10A NCAC 13F .0902(b) Healthcare**

**Medication and treatments refused by a resident to be documented on the Medication Administration Record. The Health and Wellness Director, Resident Care Coordinator or designee to be notified of the refusal and notification and documentation of healthcare provider and responsible party per policy, by Health and Wellness Director or designee. The Health and Wellness Director, Resident Care Coordinator or designee will review the MARs on a random basis for implementation of medication or treatments. The Health and Wellness Director, Resident Care Coordinator or designee should review orders and send the Physician Order Sheet for review on a scheduled basis. Retraining on basic Medication Administration, Implementation of Orders and procedures for refused or held medications will be conducted by our consulting Pharmacist and Health and Wellness Director. Documentation of training will be maintained by the community and available for review.**

**Completion Date: April 7, 2016**

**10A NCAC 13F .1002(a) Medication Orders**

**The Health and Wellness Director and Executive Director will re-train Med Techs on processing and clarifying physician orders including those on an FL-2. New order tracking forms will track physician order processing including order clarification, transcription accuracy and receipt of medications. The HWD/RCC/designee will**

review new order tracking forms to monitor accuracy and receipt of medications. Monitoring will be ongoing with new order tracking form.

Completion Date: April 7, 2016

10A NCAC 13F .1004(a) Medication Administration ---Type B

Medication Technicians to administer medications and treatments as ordered by a licensed prescribing practitioner. The Health and Wellness Director/designee will randomly audit medication passes with Medication Technicians to maintain compliance with standard medication administration practices.

Medication Technicians to complete the MAR Audit at the end of each shift per policy. It is the responsibility of the Health and Wellness Director/designee to monitor Medication Administration Records and MAR Audits to maintain compliance.

Training will be conducted for the medication Technicians, which will review standard medication administration procedures, including medications which may/may not be crushed. Documentation of medication administration will also be reviewed. This retraining will be conducted by our Health and Wellness Director or Pharmacist. Documentation of this training will be maintained by the community and available for review.

Completion Date: April 7, 2016

G.S. 131D-21 (2) Declaration of Residents' Rights

It is the practice of this community to fully respect residents' rights, and to provide care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. Staff will be retrained on Resident Rights as of April 7, 2016.

Amie James

Amie James, Executive Director

3/16/2016

Date