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 _____	R 07/15/2016

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
{D 000}	Initial Comments The Adult Care Licensure Section and the Union County Department of Social Services conducted a follow-up survey on July 14 and July 15, 2016.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (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: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 6 sampled residents (Resident #1) regarding the administration of a stool softener medication that had been discontinued. The findings are: Review of Resident #1 current FL2 dated 06/13/16 revealed: -Diagnoses included dysphagia, dementia, insomnia, glaucoma, and blepharitis. -A prescribing practitioner's order for Colace (stool softener) 100 mg daily. Review of Resident #1's previous FL2 dated 06/17/15 revealed a prescribing practitioner's order for Colace 10mg twice daily.	{D 358}		

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{D 358}	Continued From page 1 Review of Resident #1's resident register revealed an admission date of 06/29/15. Review of Resident #1's May 2016 Medication Administration Record (MAR) revealed an entry for Colace 10mg twice daily and documentation of administration at 8:00 am and 8:00 pm. Review of Resident #1's June 2016 MAR revealed an entry for Colace 100 mg twice daily and documentation of administration at 8:00 and and 8:00 pm. Review of Resident #1's July 2016 MAR revealed an entry for Colace 100 mg twice daily and documentation of administration at 8:00 am and 8:00 pm. Interview on 07/15/16 at 10:45 am with a representative of the prescribing practitioner's office revealed: -The prescribing practitioner was not aware the Colace 100 mg had been administered twice daily. -The prescribing practitioner intended for the Colace 100 mg to be administered one time daily. Interview on 07/15/16 at 9:45 am with a MA revealed: -New medication orders were faxed to the pharmacy. -When the medication arrived at the facility, the order was transcribed to the MAR. -The resident's family was notified of medication change. -The new medication order was entered in the new order tracking book. -The order would be verified by the Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD).	{D 358}		

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{D 358}	Continued From page 2 Interview on 07/15/16 at 9:48 am with the RCC revealed: -New orders were placed in the new order tracking book. -Information about the new order was shared during the shift change report. -Resident #1's current FL2 had been reviewed by herself, and she had missed the order. Interview on 07/15/16 at 10:10 am with the HWD revealed: -New orders were faxed to the pharmacy. -The new order was signed by 2 staff members. -The new order was placed in the new order tracking book. Interview on 07/15/16 at 9:55 am with the Administrator revealed: -New orders were added to the new order tracking book, and monitored by the RCC and HWD. Based on observation, record review, it was determined Resident #1 was not interviewable.	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment;	D 367		

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D 367	Continued From page 3	D 367		

(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to record on the medication administration records (MAR) immediately following administration of the medication for 1 of 4 residents observed during the morning medication pass on 07/15/16 (Resident #6).

The findings are:

Review of Resident #6's current FL2 dated 12/11/15 revealed:
-Diagnoses included depression, history of CVA, and BPH with obstruction.

Review of the Resident Register revealed Resident #6 was admitted to the facility on 12/23/15.

Observation on 07/15/16 at 7:45 am revealed:
-As each medication was prepared for administration, the Medication Aide (MA) put a tic mark in the initial box of the MAR corresponding to the correct date and time of administration.
-Medications ordered and prepared for administration included: finasteride 5 mg (used

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for benign prostatic hyoerplasia), folic acid 1 mg (used for anemia), mirtazapine 45 mg (used for depression), tamsulosin HCL 0.4 mg (used for an enlarged prostate), divaloprex 12.5 mg (used to treat manic episodes) and buspirone HCL 5 mg (used for anti-anxiety).
-Resident #6 was identified by the MA.
-Hand sanitizer was properly applied prior to the medication administration.
-The scheduled medications were provided to Resident #6 with a 4 ounce plastic cup of water.
-Resident #6 swallowed the medications without difficulty.
-The MA did not put her initials on the MAR indicating administration of the medication.
-The MA began administering medications to another resident.

Interview on 07/15/16 at 10:30 am with a MA revealed:
-The MA prepared medication for administration following the six medication rights: right time, right dose, right medication, right resident, right route and right documentation.
-The MA usually initialed the MAR in the appropriate box indicating medication administration after the administration was completed and before the next resident's medication was prepared.

Interview on 07/1516 at 10:10 am with the Resident Care Coordinator (RCC) revealed:
-The MA observed during the morning medication pass usually worked the night shift and had stayed over this morning because another MA had called out of work.
-The MA was probably nervous because of the observation of the medication pass, that she was usually great at her job.
-The MAR was normally initialed by the MA on

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D 367	Continued From page 5 duty after the medication was administered, and before the administration of medication to the next resident. Interview on 07/15/16 at 10:15 am with the Health and Wellness Director (HWD) revealed: -The MA on duty was nervous because of the observation of the medication pass on her cart, she was a night shift MA and had stayed over to help out. -The MAs were trained to initial the MAR after the medication administration was completed and before administering medications to the next resident.	D 367		