STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060049	A. BUILDING: _____ B. WING _____	01/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CARRIAGE CLUB PROVIDENCE II	5816 OLD PROVIDENCE ROAD CHARLOTTE, NC 28226

(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 survey on January 5-6, 2017.	D 000	Health and Wellness Director or deisgnee will audit all resident medication administration records for accuracy by February 10, 2017.	
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (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: (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; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medication orders were clarified for 1 of 3 sampled residents (Resident #2) with a physician's order for Oxycodone (used to treat moderate to severe pain). The findings are: Review of Resident #2's current FL2 dated 10/03/16 revealed: -Diagnoses included early Alzheimer's dementia, coronary artery disease, general weakness, history of vertebral compression fracture and malignant melanoma, essential tremors, and chronic pain.	D 344	All new mediation orders will be reviewed by two associates to assure accuracy. MD shall be contacted for verification or clarification of orders if needed and documented in the resident's record. Medication orders will be audited weekly x1 month, then monthly thereafter. All medication aides and Nurses will be retrained on how to process new orders by February10, 2017	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Santina Wright Rpn — TITLE: AIT — (X6) DATE: 1/20/17

Reviewed and accepted
tyld 1/23/17

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D 344	Continued From page 1 -A physician's order for Oxycodone 15 mg 3 times daily. Review of Resident #2's Resident Register revealed an admission date of 10/27/16. Review of Resident #2's record revealed: -A Medication Review Report signed by Resident #2's physician on 11/17/16 with an entry for Oxycodone 5mg "give 3 tablets 3 times a day". -A physician's order dated 11/22/16 for Oxycodone 15 mg 2 times daily. Review of Resident #2's November, December and January 2016 electronic Medication Administration Records (eMARs) revealed an entry for "Oxycodone 5 mg give 3 tablets 3 times a day" and documented as administered at 8:00 am, 3:00 pm and 8:00 pm from 11/02/16 to 1/04/16 except it was documented "other/see nurses notes" for the 8:00 am doses on 11/19/16 and 11/20/16, and the 3:00 pm dose on 1/02/17 and was not given on these days. Review of Resident #2's "Resident Log" for staff documentation revealed: -Documentation by a nurse dated 11/19/16 at 9:45 am that the Oxycodone supply would be out, and that the nurse had contacted the pharmacy supplier, the physician on call, and the Nurse Practitioner for a refill order but it would not be available until 11/20/16, and "staff were to administer Tylenol (used to treat minor pain) along with other pain meds". -There was documentation on 1/02/17 that Resident #2 was out of the facility when the 3:00 pm dose of Oxycodone was scheduled to be administered. Telephone interviews on 1/05/17 at 2:50 pm and	D 344		

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D 344	Continued From page 2 1/06/17 at 9:20 am with the facility's back-up pharmacy representative revealed: -Resident #2's current order for Oxycodone was 15 mg 3 times a day with 270 tablets dispensed on 11/21/16 and written by a Nurse Practitioner with no refills available. -They would fax a copy of the "hard script" for Resident #2's Oxycodone. -Medications were filled based on physician's orders in the system, and not by what the facility staff entered into the eMAR system. Review of a faxed copy sent on 1/06/17 by the pharmacy of Resident #2's most recent prescription revealed an order dated 11/21/16 by the Nurse Practitioner for "Oxycodone 5 mg (3) tablets 3 times a day". Review of medications on hand for Resident #2 on 1/06/17 revealed: -Two Oxycodone 5 mg bingo cards each with 90 tablets, dispensed on 11/21/16, and labeled to administer 3 tablets, 3 times a day. -Each bingo pocket contained 3 tablets. -One card was full with 30 doses (90 tablets) and the other card had 14 doses (42 tablets) available to be administered. -There were matching Oxycodone sign out sheets with appropriate documentation, and matching medication counts. Telephone interview on 1/05/17 at 4:30 pm with Resident #2's physician revealed: -Resident #2 was receiving Oxycodone for chronic pain issues. -Resident #2 was a recent admission on numerous medications, and the physician "would like to adjust his medications, but it can not be done all at once". -He had not discussed tapering Resident #2's	D 344		

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D 344	Continued From page 3 Oxycodone dosage with family or staff, but would like to eventually taper it to a prn (as necessary) medication if the resident tolerated it. -He was not aware that the 11/22/16 prescription he wrote was for Oxycodone 2 times a day, as the resident still needed the medication 3 times per day. -Resident#2's back pain was currently better, so he would wait before adjusting pain medications. Interview on 1/06/17 at 8:00 am with the Administrator-in-Training revealed: -Physician orders and prescriptions were faxed to the pharmacy, but the facility nurses entered orders into the eMAR system. -"I think the nurse thought the 11/22/16 hard script (for Resident #2's Oxycodone) was a refill and did not notice it was for 2 times a day, so did not change the order in the eMAR". -She thought "the pharmacy filled medication orders based on what was entered into the (eMAR) system". -She contacted Resident #2's physician yesterday because she could not remember any discussions about weaning Resident #2's medications, and the physician thought it was an oversight that he wrote Oxycodone for 2 times per day. Further review of Resident #2's record on 1/06/17 revealed: -An order clarification dated 1/05/17 for "Oxycodone 5mg, take 3 tablets 3 times a day". Interview on 1/06/17 at 8:30 am with a Medication Aide (MA) revealed: -She had worked at the facility for more than 8 years. -New orders were faxed to the pharmacy by either a MA or the nurse, but entered into the	D 344		

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D 344	Continued From page 4 computer system by the nurse. -"I also contact the pharmacy to confirm they received the fax and to confirm the medication was coming that night." Interview on 1/06/17 at 8:35 am with another MA revealed: -She had worked at the facility for 2 years. -Only the nurses entered new orders into the eMAR system, but anyone could fax the order to the pharmacy. -If orders were changed, "like from a physician appointment", each shift was updated to changes by the shift report sheet. Medication changes would show up in the eMAR, or not be there if the medication was discontinued. Interview on 1/06/17 at 8:45 am with a nurse revealed: -She verified physician orders and prescriptions, faced them to the pharmacy, and entered the orders into the eMAR. -MA did not enter orders into the eMAR system at this time. -Pharmacy did not enter orders into the eMAR system. -If the pharmacy saw an order was entered into the system different from the actual order, then the pharmacy "called us to check". -Resident #2 used one pharmacy to fill his medications unless it was needed after hours, "then we would contact his wife for permission to fill from our main pharmacy". Telephone interview on 1/06/17 at 9:00 am with Resident #2's primary pharmacy's representative revealed: -Oxycodone 15 mg 3 times a day was dispensed on 11/23/16, "and he is overdue to be refilled". -Resident #2's current order for Oxycodone was	D 344		

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D 344	Continued From page 5 dated 11/22/16 for 15 mg 2 times a day, but it was placed on hold "probably from under dosing" since Resident #2 had been on Oxycodone 15 mg 3 times a day since August 2015. There was no documentation in the system regarding the hold note. -The pharmacy defaults to the most recent order in the system. -The pharmacy staff would contact the physician if a new order was different. -"We talk to the (Resident #2's) physician or NP frequently (during the day), so the order/note could have been put in a pile to check with the physician or NP the next time they called. Everyone that day might have been on the same page to hold the new order (Oxycodone 2 times a day) because of the long term use of 3 times a day." "If we were busy, we might have not put a note in the system for why the (new) order was held." -He was not involved in the hold order, but it was "a long time ago to remember since staff handled so many prescriptions every day". No other pharmacy staff were available at this time to ask if they recalled the hold note. Based on observations, record review, and interviews, it was determined Resident #2 was not interviewable.	D 344		