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
	HAL041030	A. BUILDING: _____ B. WING _____	03/17/2017

RECEIVED APR 20 2017 ADULT CARE LICENSURE SECTION

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT	201 WEST HARTLEY DRIVE HIGH POINT, NC 27265

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on March 15-17, 2017.	D 000		
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: Based on observations, interviews, and record reviews, the facility failed to assure implementation of physician orders for 1 of 5 sampled residents (Resident #3) with physician's orders for laboratory work (ammonia level, uric acid level, chest x-ray (CXR) and Basic Metabolic Panel (BMP). The findings are: Review of Resident #3's current FL2 dated 2/15/17 revealed diagnoses included congestive heart failure, seizures, chronic kidney disease and chronic obstructive pulmonary disease. Review of Resident #3's record revealed: -A physician's order (primary physician) dated 12/07/16 for CXR for crackles to Right middle lobe and diminished lung sounds to right lower lobe and a BMP and ammonia level.	D 276		

Reviewed and accepted
4/25/17 LJW

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D 276	Continued From page 1 -A physician's order (nephrologist) dated 12/14/16 to obtain a BMP, uric acid and ammonia level in one month.. -There were no chest x-ray results for the month of December 2016. -There were no ammonia laboratory results for the month of December 2016. -There was a Complete Metabolic Panel (CMP) dated 12/26/16 (which included the information needed in a BMP). -The ordered laboratory tests for a uric acid level and an ammonia level were not obtained until March 2, 2017. Interview with Resident #3 on 3/17/17 at 11:49 am revealed: -She had her blood drawn recently, but did not know what they were or why they were drawn. -She did not know if there were labs ordered that were not drawn. -She never refused to have any laboratory work done. Interview with a Medication Aide (MA) on 3/16/17 at 6:23 pm revealed: -Most often the orders for laboratory tests and CXR are already handled by first shift. -If she got an order for laboratory testing or a CXR, she would put it on the designated clip board and the Health and Wellness Director (HWD), Resident Care Director (RCD) or the nurse would handle the orders from there. -She did not know Resident #3 had laboratory orders or orders for a CXR. Interview with the (RCD) on 3/17/17 at 9:55 am revealed: -If a laboratory test was ordered by an outside physician, the ordering physician would set up the laboratory test or make a follow-up appointment	D 276		

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for the resident to have laboratory tests obtained.
-She did not know why Resident #4 did not have CXR results on or around 12/07/16 because they typically obtained CXR results the same day they were ordered.
-Resident #3 may have refused to have laboratory tests drawn but there was no documentation of a refusal.

Interview with Resident #3's primary care practitioner on 3/17/17 at 4:13 pm revealed:
-She was not aware the laboratory tests and CXR she ordered were not completed.
-There had been significant problems keeping track of orders in this facility.
-She would expect a CXR to be obtained the day it was ordered.

Interview with a nurse from Resident #3's nephrologist on 3/17/17 at 12:19 pm revealed:
-The neurologist did order a BMP, ammonia level and uric acid level to be drawn one month from 12/12/16.
-They expected the orders be drawn at the facility and the results be faxed to their office.
-Resident #3 missed an appointment scheduled for 1/25/17.
-They did not have any laboratory results for the uric acid and ammonia levels that were due around 1/14/17.
-On 3/10/17 the facility rescheduled an appointment for Resident #4 on 3/22/17 and they would review outstanding laboratory work at that time.

Interview with the Administrator on 3/17/17 at 1:23 pm revealed:
-She expected staff to make sure the order was clear and contact the laboratory if the laboratory test ordered was stat.

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D 276	Continued From page 3 -If the order was not stat, staff was to place the order in the lab order folder. -The was to staff fill out the preliminary information on the laboratory requisite -The phlebotomist from the contracted outside agency was to complete the form and was to sign and date the form once the laboratory draw was complete. -The laboratory would send the results to both the facility and the physician. -She did not know why the ordered laboratory tests were not obtained months after they were ordered.	D 276		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents (#9 and #10) observed during the medication passes, including Depakote (#10), and an antacid (#9), and 2 of 5 sampled residents (#2, #3) including a medication for an infection (#2, #3) and an anticoagulant (#2).	D 358		

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D 358	Continued From page 4 The findings are: A. Review of Resident #3's current FL2 dated 2/15/17 revealed: -Diagnoses included congestive heart failure, hypertension, chronic kidney disease, diabetes mellitus II and edema. Review of a physician's orders revealed: -An order dated 3/01/17 for doxycycline 100 mg 1 capsule 4 times a day (a medication used to treat bacterial infections). -An order clarification dated 3/02/17 for doxycycline 100 mg 1 capsule every twelve hours for 7 days. Review of Home Health progress notes dated 3/01/17 revealed: -Resident #3's left lower leg wound had an odor and yellow and green drainage. -The home health nurse reported the condition of the wound and requested an antibiotic from Resident #3's primary care physician. Review of the Home Health progress notes dated 3/03/17 revealed: -The left lower extremity wound had an odor with thick green drainage and the skin was sloughing off. -The Home Health nurse reported the condition of the left lower extremity to the primary care practitioner and recommended Resident #3 be sent to the local emergency department. Review of emergency department History and Physical report dated 3/03/17 revealed: -Resident #3 was evaluated for cellulitis of the chronic wounds on the left lower extremity. -Resident #3 had a diagnosis of cellulitis.	D 358		

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D 358	Continued From page 5 -Her left leg had not improved with the antibiotics she was prescribed. -"Initially, there were plans to start another antibiotic today but eventually the decision was made to refer her to the hospital for further management." -Resident #3 was admitted to the hospital. Review of the hospital Discharge Summary revealed she was discharged from the hospital 3/07/17 having been treated for cellulitis. Review of Resident #3's March 2017 electronic Medication Administration Record (eMAR) revealed: -There was an entry for doxycycline 100mg 1 tablet every 12 hours for 7 days with a start date of 3/03/17. -The doxycycline was scheduled to be administered at 8:00 am and 8:00 pm and documented as not given due to hospitalization at 8:00 pm on 3/03/17 through 3/06/17 and 8:00 am on 3/04/17 through 3/07/17. Review of the hospital Discharge Summary revealed she was discharged from the hospital 3/07/17 and the "patient was treated with vancomycin (an antibiotic used to treat bacterial infections, local wound care with good improvement." Interview with Resident #3 on 3/17/17 at 11:49 am revealed: -She did not take any antibiotic before she went to the hospital. -She was in the hospital for about 5 days for cellulitis. -Her left lower leg was "red, raw and it hurt so bad". -She did take an antibiotic or two after the	D 358		

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D 358	Continued From page 6 hospitalization, but she did not know what they were called. Interview with the Home Health nurse on 3/16/17 at 3:53 pm revealed: -She referred Resident #3 to the hospital because her left lower leg presented with cellulitis and there had been no improvement since her last visit on 3/01/17. -She was unaware Resident #3 never started the antibiotic. Interview with a representative from the contracted pharmacy on 3/16/17 at 4:32 pm revealed: -They received Resident #3's doxycycline order on 3/02/17 at 2:59 pm. -The pharmacy filled 14 tablets of doxycycline on 3/02/17. -The doxycycline was transported from the pharmacy at 7:57 pm and likely arrived at the facility between 10:00 pm and 12:00 am. -They did have a back-up pharmacy that would courier medication to the facility so medication can be started quickly if needed. -The facility had to request the use of the back-up pharmacy. -They did not receive a request from the facility to have the medication called into the back up pharmacy. Interview with Resident #3's primary care practitioner on 3/16/17 at 4:13 pm revealed: -She ordered Resident #3 doxycycline on 3/01/17. -She clarified the frequency and stop date of the doxycycline order the next day. -She expected staff to start the doxycycline for Resident #3 the day she ordered it or at least the day the order was clarified.	D 358		

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D 358	Continued From page 7 -She was not aware Resident #3 never started the antibiotic. -It was possible if Resident #3 started the doxycycline when it was ordered the antibiotic could have slowed the progression of the cellulitis enough to avoid hospitalization. Interview with a MA on 3/16/17 at 3:17 pm revealed: -When they received an order for an antibiotic the MAs were to fax it to the pharmacy and start it as soon as possible. -She thought when she entered a medication into the eMAR the program automatically started the medication for the next day. -She did not think there was an option to set the time for the same day the medication was ordered. -Upon demonstration, the MA opened the eMAR of a resident that was ordered an antibiotic that morning. -She demonstrated how a medication could be started the same day it was ordered and setting the time of the medication was the only option the program offered. -She thought she must have looked at it incorrectly in the past. -She did not enter Resident #3's antibiotic into the eMAR. -The MAs were able to call medications into the back up pharmacy if the medication was needed quickly. Interview with a second MA on 3/17/17 at 10:09 am revealed: -Antibiotics were to be administered as soon as they get the physician's order. -They were to fax the order to the pharmacy and if they faxed the order before 3:00 pm the antibiotic would be delivered to the facility late in	D 358		

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D 358	Continued From page 8 the evening the same day. -If they faxed an order after 3:00 pm the medication would not come until the next day and the MAs were to call the pharmacy and request it be sent into the back up pharmacy. Interview with the Administrator on 3/17/17 at 1:23 pm revealed: -She expected antibiotic orders be started the same day they were received. -The MAs were expected to call the back up pharmacy and have the medication delivered to the facility so the resident could start the antibiotic the same day. -She was not aware Resident #3 did not start an antibiotic before being admitted to the hospital. Refer to interview on 3/15/17 at 4:35 pm with the Resident Care Director (RCD). Refer to interview on 3/15/17 at 4:50 pm with a Regional Administrator. Refer to interview on 3/16/17 at 10:50 am and 11:40 am with the Registered Nurse (RN) Case Manager. Refer to interview on 3/16/17 at 11:30 am with an Administrator/Executive Director. Refer to interview on 3/16/17 at 6:20 pm with a 2nd shift MA. B. Review of Resident #10's current FL2 dated 8/17/16 revealed: -The resident's diagnoses included epilepsy and depression. -A physician's order for Depakote 500mg every evening.	D 358		

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D 358	Continued From page 9 Review of a physician's order dated 2/01/17 revealed Resident #10's Depakote was changed to 500 mg 1 tablet twice daily. Observation of the medication pass on 3/16/17 revealed: -At 9:35 am the MA placed two tablets of Depakote 500 mg into the medication cup along with 7 other medications. -Resident #10 took all the medication in the medication cup with approximately 6 ounces of water at 9:39 am. -She documented the administration of the medications into the electronic Medication Administration Record (eMAR) directly after Resident #10 swallowed the medications. Interview with the MA on 3/16/17 at 3:17 pm revealed: -She administered according to the instructions on the eMAR. -She was not aware that Resident #10 was only to have 1 Depakote 500mg tablet. -She assumed the eMAR was accurate. -Resident had several recent changes to the Depakote and she did not question the amount. -Orders were entered into the eMAR by the MAs and she thought the entries were verified by the nurse or the Resident Care Director (RCD). Review of the March 2017 eMAR for Resident #10 revealed: -There was a computer generated entry dated 2/10/17 for Depakote 500mg 2 tablets twice daily at 10:00 am and 8:00pm. -The Depakote was documented as administered at 10:00 am on 3/01/17 through 3/16/17 and 8:00 pm on 3/01/17 through 3/15/17. Resident #10 was unavailable for interview	D 358		

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D 358	Continued From page 10 3/16/17 at 3:30 pm. Interview with the RCD on 3/16/17 at 11:00 am revealed: -She had been the RCD for approximately one month. -The last order in the record was Depakote 500mg 1 twice daily and dated 2/01/17. -She did not know what the order for Depakote was, but would clarify it with the physician. -There was not a physician's order or a new order tracking form for the entry on the eMAR for Depakote 500 mg twice daily. -She would have checked the order to ensure entry was accurate if she had been given an new order tracking form because the forms cue her to check the new orders. -She did not know why the order was changed in the eMAR on 2/10/17. Interview with the RCD on 3/17/16 at 11:15 am revealed she received order clarification and Resident #10 was to be taking Depakote 500 mg 1 tablet twice daily. Attempted interviews with Resident #10's psychiatric practitioner on 3/17/17 at 1:50 pm were unsuccessful by exit. Interview with the MA on 3/16/17 at 3:17 pm revealed: -New orders were to first be faxed to the pharmacy. -She would often call and verify the pharmacy received the fax. -The physician order was to be entered into the eMAR and then placed in the resident's record. -MAs were also expected to document the new order in the resident's record. -A new order tracking form was to be filled out	D 358		

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D 358	Continued From page 11 and placed in the new order tracking form folder. -She thought "the nurse or possibly the RCD" checked all the eMAR entries to ensure accuracy. Interview on 3/15/17 at 4:50 pm with a Regional Administrator revealed: -She was covering for the Administrator and was at the facility only for today. -The facility had an "order tracker" system in place so that orders were not missed. -The nurses were responsible for verifying orders were entered correctly in the eMAR system. Interview on 3/16/17 at 11:30 am with the Administrator revealed: -She had worked at the facility 2 days per week since December 2016 and shared duties with another Administrator since February. -The RCD position had changed several times over the past year, and was a nurse position. -The RCD was a LPN who had been transferred from another facility. -The facility had been using nursing staff to cover from other facilities until the position was filled permanently. -The current RN worked at the facility only "several days a week". -The nurses were responsible for verifying orders were entered correctly in the eMAR system. Refer to interview on 3/15/17 at 4:35 pm with the Resident Care Director (RCD). Refer to interview on 3/15/17 at 4:50 pm with a Regional Administrator. Refer to interview on 3/16/17 at 10:50 am and 11:40 am with the Registered Nurse (RN) Case Manager.	D 358		

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D 358	Continued From page 12 Refer to interview on 3/16/17 at 11:30 am with an Administrator/Executive Director. Refer to interview on 3/16/17 at 6:20 pm with a 2nd shift MA. C. Review of Resident #9's current FL2 dated revealed: -The resident's diagnoses included essential hypertension. -A physician's order for antacid-antigas (mylanta) 400-400-40mg/5ml to be given as needed for heartburn/gas. Observation of the medication pass on 3/16/17 revealed: -At 9:42 am Resident #9 requested her medication for heartburn. -The MA poured 15 mls of double-strength mylanta. -The MA handed the liquid medication to Resident #9. Review of the March 2017 eMAR for Resident #9 revealed: -An entry for mylanta double strength suspension 400-400-40mg/5ml give 5ml as needed for antacids. -On 3/11/17, mylanta double strength was documented as administered at 2:41 pm and documented as effective. -On 3/16/17, mylanta double strength was documented as administered at 9:43 am and effectiveness was not yet documented. Interview with the MA on 3/16/17 at 9:43 am revealed: -She thought she poured 5cc's of the mylanta but the lines on the medication cup were very hard to see.	D 358		

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D 358	Continued From page 13 -She knew to pour the liquid medication at eye level and on a level surface. Interview with Resident #9 on 3/17/17 at 1:16 pm revealed: -Some of the MA's pour just a tiny amount of the mylanta in the medication cup and it is not effective. -There was one MA that gave her a little bit more than the others and this amount was effective for her heartburn. -She never asked her physician if she could have more or reported to the MAs that the "tiny amount" was ineffective. Refer to interview on 3/15/17 at 4:35 pm with the Resident Care Director (RCD). Refer to interview on 3/15/17 at 4:50 pm with a Regional Administrator. Refer to interview on 3/16/17 at 10:50 am and 11:40 am with the Registered Nurse (RN) Case Manager. Refer to interview on 3/16/17 at 11:30 am with an Administrator/Executive Director. Refer to interview on 3/16/17 at 6:20 pm with a 2nd shift MA. D. Review of Resident #2's current FL2 dated 8/18/16 revealed: -The FL2 was completed at a skilled nursing facility and signed by a physician, with a discharge plan for an assisted living facility. -Page 1 was an official FL2 form with typed data entered. There was no documentation to indicate this was page 1 of 2. -There was a blank paper with Resident #2's	D 358		

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D 358	Continued From page 14 name and date of birth documented at the top, with a "Medical Diagnosis continued" followed by 2 diagnoses, and "Medication continued" followed by 9 medications, with a physician's signature dated 8/18/16 at the bottom of the page. -Diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, hemiplegia and hemiparesis following a cerebral infarction, "old myocardial infarction" (MI), Takotsubo syndrome (also known as stress cardiomyopathy), and hyperlipidemia. -Physician medication orders on page one included Amlodipine 2.5 mg every morning (used to treat hypertension), aspirin 81 mg every morning (a blood thinner), atorvastatin 20 mg every evening (used to lower cholesterol), and citalopram 10 mg every morning (an anti-depressant). -Physician medication orders on the "medication continued" page included clopidogrel 75 mg at bedtime (a blood thinner used to prevent stroke and heart attack), diphenhydramine 25 mg every 6 hours as needed (an antihistamine), docusate sodium 100 mg twice a day (a stool softener), Fentanyl patch 12 mcg apply transdermally in the evening every 3 days (used for pain relief), Melatonin 3 mg at bedtime (a sleep aide) , multi-vitamin with minerals 1 tablet every morning (a vitamin and mineral supplement), Nitroglycerin 0.4mg sublingually (SL) every 5 minutes as needed for chest pain (used to treat and prevent chest pain), oxycodone-acetaminophen 5-325 mg every evening (used to treat moderate to moderately severe pain), and polyvinyl alcohol solution 1.4% 1 drop each eye as needed (used to relieve dry eyes). Review of Resident #2's Resident Register revealed an admission date of 9/14/16.	D 358		

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D 358	Continued From page 15 1. Review of Resident #2's record revealed: -Copies of hard-script physician orders for Fentanyl patch 12 mcg every 3 days at bedtime dated 8/31/16, 10/12/16, 11/17/16, 12/21/16, 2/01/17, and 3/08/17. -Copies of hard-script physician orders for oxycodone-acetaminophen 5-325 mg every bedtime dated 8/31/16, and 10/12/16. - A physician's order dated 11/17/16 to increase oxycodone-acetaminophen to 10-325 mg every bedtime. -A physician's order dated 12/26/16 to discontinue oxycodone-acetaminophen. -A physician's order dated 10/20/16 for Nitroglycerin 0.4 mg sublingually every 5 minutes as needed for chest pain. -A "Medication Review Report" dated 12/21/16 and signed by the Nurse Practitioner (NP) on 12/22/16 listing all medications from the 8/18/16 FL2 page one, but only Duragesic (Fentanyl), Percocet (oxycodone-acetaminophen), and Nitroglycerin were from the "medication continued" page. -There were no discontinued orders for clopidogrel, diphenhydramine HCL, docusate, melatonin, multi-vitamin with minerals or polyvinyl alcohol solution. Review of the quarterly pharmacy reviews revealed: -The review completed 10/07/16 did not include the "medication continued" page of the FL2 dated 8/18/16. There was documention for "has a cardiac issue-need Nitroglycerin SL (sublingual)?" was listed for recommendations and follow-up with the physician. -The review completed 1/05/17 did not include the medication continued" page of the FL2 dated 8/18/16. There was no documentation listed for recommendations or follow-up.	D 358		

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D 358	Continued From page 16 Review of Resident #2's September 2016, October 2016, November 2016, December 2016, January 2017, February 2017, and March 2017 electronic Medication Administration Records (eMAR) revealed: -The "medication continued" page of medications from the 8/18/16 physician orders were not on the eMARs except Duragesic, Percocet and Nitroglycerin. -There was no entry for clopidogrel 75 mg at bedtime. -There was no entry for diphenhydramine HCL 25 mg every 6 hours as needed. -There was no entry for docusate 100 mg twice a day. -There was no entry for melatonin 3 mg at bedtime. -There was no entry multi-vitamin with minerals 1 tablet every morning. -There was no entry for polyvinyl alcohol solution 1.4 % 1 drop each eye every 8 hours as needed. -There was no entry for Nitroglycerin 0.4 mg SL every 5 minutes x3 as needed on the September 2016 MAR, but it was included on the eMARs starting 10/20/16. Review of a faxed order for Resident #2 from the Nurse Practitioner dated 3/16/17 and timed 4:53 pm revealed: -An order "to continue Plavix (clopidogrel) 75 mg every bedtime. -An order to discontinue Benadryl (diphenhydramine HCL). -An order to discontinue Colace (docusate). -An order to discontinue melatonin. -An order to discontinue multi-vitamin. -An order to discontinue polyvinyl alcohol solution. Interview on 3/15/17 at 3:45 pm with Resident #2	D 358		

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D 358	Continued From page 17 revealed: -She did not know the names of the medications ordered by the physician, and took the medications that the staff administered to her. -She had partial paralysis affecting her left side after a stroke. Interview on 3/15/17 at 4:10 pm with the facility's contracted pharmacy representative revealed: -They provided medications for Resident #2. -There were medication orders from an FL2 dated 8/18/16, but it was one page only. They did not have a "medication continues" page dated 8/18/16 with orders. The fax tag said "1 of 1 page", so no other pages were faxed with the FL2. -Clopidogrel was last filled 4/06/16, was discontinued on 4/14/16, and there was no active order in the system. -Diphenhydramine HCL was ordered 1/26/16, last filled 2/15/16 from a refill sheet, but discontinued on 4/2/16, and there was no active order in the system. -Docusate was last filled 4/06/16, was discontinued on 4/14/16, and there was no active order in the system. -There was no order in their system for Resident #2 for melatonin. -Multi-vitamin with minerals was last filled on 4/06/16, was discontinued on 4/14/16, and there was no active order in the system. -Nitroglycerin SL was filled 4/06/16, discontinued on 4/14/16, and was re-ordered on 10/20/16 as Nitroglycerin 0.4 mg SL every 5 minutes x3 as needed. -Polyvinyl Alcohol 1.4% solution was last filled 4/06/16, was discontinued on 4/14/16, and there was no active order in the system. Review of the facility's order tracker system on	D 358		

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D 358	Continued From page 18 3/16/17 revealed: -The tracker system was a paper that staff were to complete that included the resident's name and order detail, and spaces to initial including that the order was entered into the eMAR, faxed to pharmacy, clarified if needed, and medication arrived. -The form was to be sent to the Resident Care Director (RCD) when completed. Interview on 3/15/17 at 4:35 pm with the RCD revealed: -The "medication continues" page of Resident #2's FL2 should have been faxed to the pharmacy by the medication aide (MA), and should have been entered into the eMAR system by the MA. Interview on 3/15/17 at 4:50 pm with a Regional Administrator revealed: -The facility had an "order tracker" system in place so that orders were not missed. The tracker system should have caught Resident #2's page 2 of medication orders from the FL2. Interview on 3/16/17 at 4:10 pm with Resident #2's Nurse Practitioner (NP) revealed: -She was not aware there was a second page of medication orders with the FL2 dated 8/18/16 with 6 medications the resident had not received since admission on 9/14/16 that included Clopidogrel, diphenhydramine HCL, docusate, melatonin, multi-vitamin with minerals, and polyvinyl alcohol solution eye drops. -There could be clinical implications in not receiving clopidogrel with Resident #2's history of stroke, but she was not as concerned with Resident #2's history of MI the resident was receiving aspirin. -The facility had notified the office today (3/16/17)	D 358		

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D 358	Continued From page 19 of the second page of missed orders. 2. Review of a Discharge Summary for Resident #2 dated 2/04/17 revealed: -The resident was admitted to the hospital on 2/01/17 and hospitalized from 2/01/17 to 2/04/17 for sepsis and pneumonia. -A copy of a physician's prescription dated 2/04/17 for amoxicillin-clavulanate (Augmentin) [an antibiotic] 875-125 mg with instructions to take 2 times a day for 4 days, and ordered to start 2/04/17 and end 2/08/17. -The "hospital course" summary documented that Resident #2 "will be discharged on Augmentin for 4 more days". -Discharge instructions were the next dose of Augmentin 875-125 mg was due at 2/04/17 at 8:00 pm. -She was not ordered any other antibiotics. Review of Resident #2's record revealed: -Documentation in the "Resident log" by a MA on Saturday, 2/04/17 at 3:00 pm: "Returned from hospital around 5:00 pm with a new order for amoxicillin 2 times a day for 4 days, and put in to be started on Tuesday 2/07/17 to give medication time to come in." -There was no order to delay starting Augmentin 875-125 mg as ordered to start on 2/04/17. Review of Resident #2's February 2017 eMAR revealed: -An entry for amoxicillin-clavulanate 875-125 mg every 12 hours for bacterial infection for 4 days and dated to start on 2/07/17 at 8:00 am. It was documented as administered at 8:00 am and 8:00 pm from 2/07/17 to 2/10/17. -Amoxicillin-clavulanate 875-125 mg was not started 2/04/17 as ordered.	D 358		

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D 358	Continued From page 20 Interview on 3/15/17 at 3:45 pm with Resident #2 revealed she did not know the names of the medications ordered by the physician, and took the medications that the staff administered to her. Interview on 3/15/17 at 3:55 pm with a second shift MA revealed: -She was new to the facility in October 2016 and had not used computers at her previous job. -The MA were to fax orders to the pharmacy and get the medications from the back-up pharmacy so the medication could be started that same night. If order clarifications were needed, that would delay a medication starting. -She had entered Resident #2's Augmentin order after her return on 2/04/17. -"I was new and did not know how to get medications from back-up. I caused the delay in starting (named resident)'s medication. I know the system now." Telephone interview on 3/15/17 at 4:10 pm with the facility's contracted pharmacy's representative revealed: -They provided medications for Resident #2. -The pharmacy received an order for Augmentin by fax on 2/04/17 after the cut off time. -"I'm not sure what happened to the order. The order was keyed into the system on 2/06/17 at 9:24 am, and was dispensed 8 tablets that went out (to the facility) at 8:49 pm." -The pharmacy dispensed medications only, and do not enter orders into the eMAR. Interview on 3/15/17 at 4:50 pm and 3/17/17 at 9:45 am with the Resident Care Director (RCD) revealed: -She was not working at the facility when Resident #2 returned from the hospital on 2/04/17.	D 358		

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D 358	Continued From page 21 -An antibiotic should be started as soon as possible and per orders. It could be obtained from the back-up pharmacy if it was after hours. -The staff should contact the Supervisor if they were not sure how to order medications. Interview on 3/16/17 at 4:10 pm with the NP revealed: -Antibiotics should have been started as soon as Resident #2 returned from the hospital. -The facility should have a process to obtain medications if it was after hours or a weekend. -The delay in starting the Augmentin could have been a problem since Resident #2 was hospitalized with sepsis and pneumonia. -There were no ill effects from the delay in starting Augmentin on Resident #2. Refer to interview on 3/15/17 at 4:35 pm with the Resident Care Director (RCD). Refer to interview on 3/15/17 at 4:50 pm with a Regional Administrator. Refer to interview on 3/16/17 at 10:50 am and 11:40 am with the Registered Nurse (RN) Case Manager. Refer to interview on 3/16/17 at 11:30 am with an Administrator/Executive Director. Refer to interview on 3/16/17 at 6:20 pm with a 2nd shift MA. Interview on 3/15/17 at 4:35 pm with the Resident Care Director (RCD) revealed: -She was a Licensed Practical Nurse (LPN). -She had been in this position for about one month and prior to that worked in a different facility owned by the same corporation.	D 358		

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D 358	Continued From page 22 -New orders, including FL2's were faxed to the pharmacy. -The MAs were responsible to enter orders into the eMAR system. -For every order entered in the eMAR system, there was an order tracking form started that goes to the nurse to verify that the orders were entered correctly in the system. Interview on 3/15/17 at 4:50 pm with a Regional Administrator revealed: -She was covering for the Administrator and was at the facility only for today. -The facility had an "order tracker" system in place so that orders were not missed. -The nurses were responsible for verifying orders were entered correctly in the eMAR system. -The pharmacy reviewer should have also caught the omission. Interview on 3/16/17 at 10:50 am and 11:40 am with the Registered Nurse (RN) Case Manager revealed: -She was a RN and had been the Case Manager for more than one year. -The facility had an order tracker system in place. Orders, including FL2's, were to be faxed to pharmacy by one staff member and entered into the eMAR system. Another staff was to review the orders, then send the tracker to the RCD or the Health and Wellness Director to verify that the orders were entered into the system correctly. Interview on 3/16/17 at 11:30 am with an Administrator/Executive Director revealed: -She had worked at the facility 2 days per week since December 2016 and shared duties with another Administrator since February. -The RCD position had changed several times over the past year, and was a nurse position.	D 358		

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D 358	Continued From page 23 -The RCD was a LPN who had been transferred from another facility. -The facility had been using nursing staff to cover from other facilities until the position was filled permanently. -The current RN worked at the facility only "several days a week". -The nurses were responsible for verifying orders were entered correctly in the eMAR system. Interview on 3/16/17 at 6:20 pm with a 2nd shift MA revealed: -New orders were to be faxed to the pharmacy by the MA, then entered onto a new order tracking system initiated by the MA. The order was to be transcribed to the eMAR by the MA or a nurse and put on the shift report sheet for discussion at shift change. -The order tracking sheet was to be initialed by the staff when steps in the process were completed. -She was not aware if the nurses double checked the tracking sheet, "they might double-check it, but I'm not sure". The facility's failure to administer medications as ordered by the physician resulted in a medication pass error rate of 6.6% (2 errors out of 30 opportunities) including Resident #9 who had a history of epilepsy and depression receiving twice the ordered amount of depakote which could have resulted in toxicity; Resident #10 which received three times the ordered amount of mylanta; Resident #3 who had a history of chronic kidney disease, diabetes mellitus II, chronic wounds and edema not receiving an antibiotic as ordered resulting in a hospitalization due to cellulitis; Resident #2 not receiving an ordered antibiotic for 3 days after a hospitalization for sepsis and pneumonia which could have	D 358		

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D 358	Continued From page 24 potentially required another hospitalization; Resident #2 who has a history of stroke and myocardial infarction not receiving an ordered anticoagulant over 8 months which could have potentially resulted in another stroke or heart attack. The failure of the facility to administer medications as ordered resulted in substantial risk of harm to residents and constitutes a Type B Violation. The facility provided a Plan of Protection on 3/16/17 as follows: -Immediately an audit will be completed by the RN Case Manager and Health and Wellness Director/Designee regarding medications on hand matching current orders, as well as any discrepancies that are found will be followed up on with the physician for clarification. -Medications received will be reviewed by the RN Case Manager and Health and Wellness Director/Designee while in the community on a daily basis for the next 30 days and thereafter the new order tracking form will be reviewed at least weekly. -Associates will be retrained on the 7 rights of administration, and on order processing. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 2, 2017.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:	D 375		

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D 375	Continued From page 25 (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure proper procedures for self-administration of medications for 4 of 4 sampled residents related to properly labeled medications for self-administration (Resident #8) and competency assessment by the facility to self-administer medications (Residents #4, #6, #7, #8), and failure to obtain a physician's order for self-administration of medications (Resident #4, #6, #7) prior to the residents administering their own medications. The findings are: Review of the facility's policies and procedures for self-administration for medications revealed: -If the resident desires to self-administer medications, an evaluation should be conducted by the Nurse, of the resident's cognitive, physical, and visual ability to carry this out. This evaluation will be completed using the Self-Administration of Medications Review form initially, quarterly, or as per state regulation and with change in resident condition. -If the resident successfully passes the self-medications evaluation, an order should be obtained from the physician and should be reflected on the Physician Plan of Care. A. Review of Resident #4's current FL2 dated	D 375		

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(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 375	Continued From page 26 2/22/16 revealed diagnoses included atrial fibrillation, congestive heart failure, metabolic encephalopathy, fluid volume overload, bladder cancer, chronic kidney disease and hypertension. Review of Resident #4's current FL2 dated 2/22/16 revealed: -An order for furosemide 20mg twice daily (furosemide is a diuretic). -There was no order for self-administration. Review of Resident #4's care plan revealed: -Resident #4 self-administers his medications and takes them whole, without difficulty. -"Medication needs will be met." Review of Self-Administration of Medications Review forms revealed: -On 1/26/15, 4/15/15, 7/27/15, 10/29/15, 1/22/16, 4/24/16 and 7/25/16, Resident #4 was deemed competent to self-administer medications and had a physician order to self-administer. -There was no Self-Administration of Medications Review evaluation conducted from 7/25/16 through 2/22/17. Review of a hospital Discharge Summary dated 10/19/16 revealed: -Resident #4 presented to the local emergency department on 10/12/16 for increasing shortness of breath. -Resident #4 had not taken furosemide for 2 and 1/2 weeks. -Resident had a history of congestive heart failure (CHF) and chronic kidney disease, stage 4 and he was in acute exacerbation of CHF. -Resident #4 was started on intravenous furosemide and respiratory status improved significantly. -There were no orders indicating Resident #4 was	D 375		

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D 375	Continued From page 27 permitted to self-administer. -Upon discharge Resident #4 had an order for levaquin 500 mg x 3 days and furosemide 40mg once daily. Review of Resident #4's Record revealed: -There was no Self-Administration of Medications Review evaluation conducted post-hospitalization. -There was no care plan re-assessment post-hospitalization. Review of Licensed Health Professional Support (LHPS) dated 12/15/16 revealed: Resident #4 was "alert and oriented but could be forgetful." Review of the October 2016 Medication Administration Record (MAR) revealed: -A computerized entry for furosemide 20mg twice daily to be administered at 8:00 am and 8:00 pm and documented as "U-SA" (unknown-self-administered) from 10/01/16 through 10/19/16, at 8:00 am and 8:00pm and 8:00 am on 10/20/16. -A computerized entry for furosemide 40mg once daily, to be administered at 8:00 am and documented as "U-SA" from 10/21/16 through 10/31/16. -A computerized entry for levaquin 500mg once daily for three days and documented as administered by staff at 8:00 pm from 10/21/16 to 10/23/16. Review of November 2016, December 2016, January, February and March 2017 MARs revealed that all medication were documented as "U-SA". Interview with Resident #4 on 3/15/17 at 4:13 pm revealed: -He stopped taking his furosemide in October	D 375		

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D 375	Continued From page 28 2016 because he was unable to get a refill from the pharmacy. -The resident and his responsible party kept track of his medications and the refills and picked his medications up from a local pharmacy after church on Sundays. -The cardiologist ordered the furosemide, but it was difficult to get an appointment. -He did report this to a MA and was told there was nothing they could do to help him because he self-administered his own medications. -He reported to his family member he was unable to get a refill on the furosemide and she made an appointment with his primary physician. -He took his medication box to the physician in January 2017 and they removed anything he was not supposed to be taking. -The facility nurse checked his medication upon admission and maybe once after that. -He was given a medication list on 1/19/17 from his primary physician. Review of medication list dated 1/19/17 revealed: -An order for acetaminophen/diphenhydramine 25/500 mg one tablet at night if needed (a medication used to treat insomnia). -An order for atenolol 100 mg take once daily (a medication used to treat high blood pressure). -An order for fluoxetine 10 mg once daily (a medication used to treat depression). -An order for meclizine 12.5 mg three times daily as needed for dizziness (a medication used to treat dizziness). -An order for nitroglycerin 0.4 mg to be placed under the tongue every 5 minutes as needed for chest pain (a medication used to prevent heart attack a relieve chest pain related to angina). -An order for omeprazole 20 mg once daily as needed for heart burn (a medication used to treat heart burn).	D 375		

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D 375	Continued From page 29 -An order for ondansetron 4 mg once every 8 hours as needed for nausea (a medication used to treat nausea). -An order for saxagliptin 2.5 mg once daily (a medication used to manage blood sugar). -An order for simvastatin 20 mg daily (a medication used to treat high cholesterol). -An order for tamsulosin .4 mg daily (a medication used to manage the symtpoms of benign prostatic hyperplasia). -An order for Vitamin B complex once daily (a medication used to supplement vitamin B in the body). -An order for warfarin 2.5 mg daily except 5mg on Wednesdays-subject to change based on coumadin clinic (a medication used to prevent the blood from clotting). Review of Resident #4's medications on hand at 3/15/17 at 4:15 pm revealed: -A locked tackle box locked with a key pad lock. -Resident #4 was able to open without difficulty. -The medications above were all present and consistent with the medication list dated 1/19/17. -Resident #4 was able to open the bottles and verbalize when he took each medication. -On Resident #4's night stand was a bottle of Augmentin 500 mg with instructions to take one tablet twice daily for 7 days, filled on 3/09/17, with one tablet remaining. Review of the March 2017 electronic Medication Administration Record (eMAR) revealed: -An entry for Acarbose 25 mg daily (not on medication list provided by Resident #4). -An entry for doxycycline 100 mg twice daily (not on medication list provided by Resident #4). -There was no entry for acetaminophen/diphenhydramine 25/500 mg one tablet at night if needed.	D 375		

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D 375	Continued From page 30 -There was no entry for fluoxetine 10 mg once daily. -There was no entry for for meclizine 12.5 mg three times daily as needed for dizziness. -There was no entry for ondansetron 4 mg once every 8 hours as needed for nausea. -There was no entry for saxagliptin 2.5 mg once daily. -There was no entry for Vitamin B complex once daily. -There was no entry for Augmentin 500 mg. Interview with the Resident Care Director (RCD) on 3/15/17 at 5:10 pm revealed: -She was not aware Resident #4 had been hospitalized for almost a week because he did not take his furosemide. -She was not aware his current eMAR did not match what he was taking. -She was not aware Resident #4 was not evaluated for self-administration of medications when Resident #4 returned from the hospital. Interview with the facility's Case Manager on 3/16/17 at 11:44 am revealed: -The self administration evaluation should have been reevaluated when Resident #4 came back to the hospital. -There was no Health and Wellness Director (HWD) last October and it was "overlooked". Interview with the Administrator on 3/17/17 at 1:20 pm revealed: -She was unaware Resident #4 was not evaluated for self-administration quarterly or when he returned from the hospital admission in October 2016. -She was not aware that Resident #4 went to the hospital because he had an acute exacerbation of CHF because he did not take his furosemide for	D 375		

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D 375	Continued From page 31 two weeks. Interview with Resident #4's primary care physician on 3/17/17 at 8:51 am revealed: -There was no corespondance between the facility or the family reporting Resident #4 was out of furosemide. -Resident #4 had a scheduled appointment 10/06/16 and Resident #4 reported to the physician he had not been taking furosemide and did not want to restart it. -The home health nurse reported to his office Resident #4 was experiencing shortness of breath on 10/12/16 and an office Visit was scheduled. -On 10/12/16, Resident #4's oxygen saturations were 79% and he was sent directly to the hospital. -There was no documentation the facility called to request a self administration order after the hospitalization. -There was no documention of a cognitive assessment indicating Resident #4 was capable of self administering his medications. Interview with Resident #4's Responsible Party (RP) on 3/16/17 at 8:57 am revealed: -Resident #4 told her he had run out of furosemide and she made an appointment with the primary physician because the resident could not be seen by the cardiologist in a timely manner. -The primary care physician instructed Resident #4 to watch for signs and symptoms of congestive heart failure and to report them to his office as soon as possible. -On 10/12/16, Resident #4 called the RP and reported he was having difficulty breathing. -She took him in to the primary care physician and Resident #4 was sent directly to the hospital.	D 375		

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D 375	Continued From page 32 -The staff at the facility told him they could not help him because he managed his own medication. -She has never known the facility to assess Resident #4 cognitively except upon admission. -No one called her and reported Resident #4 was out of furosemide. -No one from the facility called her to tell her Resident #4 was short of breath. Second interview with Resident #4 on 3/17/17 at 10:50 am revealed: -He ran out of furosemide and the pharmacy would not refill it for some reason but he did not know why. -He did not want to stop taking it, but he did not have any and he did not know what to do. -He did tell his daughter, "I was out and she told me we had an appointment with my primary doctor coming up and we could address it then". -He did not remember when he ran out but went about two weeks without furosemide. -He did tell the facility staff he was out of furosemide and was told there was nothing they could do. -He told a MA about being short of breath and they did nothing about it. "They did not even call my daughter." -The Home Health nurse came in and noticed he was short of breath and "called my daughter and the physician". -He had a "little bottle of cold medicine" in his closet but he could not open it, the staff would not open it. -He had wanted to take the cold medicine for his chest cold. -The facility nurse assessed him when he was first admitted to the facility and maybe one time after. No one ever looked at his supply or what	D 375		

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D 375	Continued From page 33 medications he took. -When he came back from the physician's office he always gave the MAs a copy of his updated medication list. -The facility used to have a nurse" but she had been gone a long time." -He did not feel like there was anyone he could go to if he had a medication or health problem. He would just tell his home health nurse or his daughter. Refer to interview on 3/15/17 at 5:10 pm with the RCD. Refer to interview on 3/16/17 at 10:50 am and 11:44 am with the RN Case Manager. Refer to interview on 3/16/17 at 6:23 pm with a second shift MA. Refer to interview on 3/17/17 at 1:20 pm with the District Administrator. B. Review of Resident #6's current FL2 dated 3/17/17 revealed: -Diagnoses included Parkinson's disease, arthritis, and a hip fracture with repair. -A physician's order "self administers his medications. Meds are stored in a locked box in room". -An original faxed date at the top of the form documenting that the facility sent the FL2 to Resident #6's physician for a signature on 3/03/17. -A physician's order for Protonix 40 mg daily (used to reduce the amount of acid in the stomach), carbidopa-levodopa 25mg/250mg three times a day (used to treat Parkinson's disease), flomax 0.4mg daily (used to treat urinary retention), sennokot-S 8.6 mg twice a day	D 375		

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D 375	Continued From page 34 as needed (used to treat constipation), Tylenol 650 mg every 6 hours as needed for pain(used to treat minor pain), and Tramadol 50 mg every 4 hours as needed for pain (used to treat moderate to severe pain). Review of Resident #6's Resident Record revealed an admission date of 8/13/13. Review of Resident #6's record revealed: -There was no physician's order for Resident #6 to self administer his medications prior to documentation that Resident #6 administered his own medications starting on 12/01/16. -There was a "Self-Administration of Medications Review" completed by a nurse on 12/22/16, but not prior to documentation that Resident #6 administered his own medications on 12/01/16. -There was a care plan dated 1/01/17 that documented "resident is self administer with his medications". Review of Resident #6's "Medication Review Report dated 2/22/17 and signed by the physician on 3/07/17 revealed an entry under "other: order summary" for "self-administers his medication. Medications are stored in a locked box in residents room" and documented as a verbal order dated 11/30/16 (which was not found in Resident #6's record and could not be provided by the staff). Review of Resident #6's November 2016 electronic Medication Administration Record (eMAR) revealed: -The facility administered all medications to Resident #6 from 11/01/16 to 11/30/16. -An entry for pantoprazole sodium (Protonix) 40 mg daily and documented as administered daily at 8:00 am from 11/01/16 to 11/30/16.	D 375		

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D 375	Continued From page 35 -An entry for tamsulosin HCL (Flomax) 0.4mg daily and documented as administered daily at 7:00 am from 11/01/16 to 11/30/16. -An entry for carbidopa-levodopa 25-250 mg before meals and documented as administered at 7:00 am, 12:00 pm, and 5:00 pm from 11/01/16 to 11/30/16. -An entry for mapap (Tylenol) 325 mg, "take 2 tablets every 6 hours as needed for pain" and no doses were documented as administered from 11/01/16 to 11/30/16. -An entry for Senexon-S 8.6mg as needed for constipation and no doses were documented as administered from 11/01/16 to 11/30/16. -An entry for Tramadol HCL 50 mg every 4 hours as needed for pain and no doses were documented as administered from 11/01/16 to 11/30/16. Review of Resident #6's December 2016 eMAR revealed: -All medications were documented as "U-SA" (unknown-self-administered) from 12/01/16 to 12/31/16, and prior to a physician's order or a nurse's assessment was completed to self-administer his medications. -An entry for pantopraxole sodium (Protonix) 40 mg daily, "unsupervised self-administration", and documented by staff as "U-SA" daily at 8:00 am from 12/01/16 to 12/31/16. -An entry for tamsulosin HCL 0.4mg daily, "unsupervised self-administration", and documented by staff as "U-SA" daily at 7:00 am from 12/01/16 to 12/31/16. -An entry for carbidopa-levodopa 25-250 mg before meals, "unsupervised self-administration", and documented by staff as "U-SA" at 7:00 am, 12:00 pm, and 5:00 pm from 12/01/16 to 12/31/16. -An entry for mapap (Tylenol) 325 mg, "take 2	D 375		

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D 375	Continued From page 36 tablets every 6 hours as needed for pain", "unsupervised self-administration", and documented by staff as "U-SA" from 12/01/16 to 12/31/16. -An entry for Senexon-S 8.6mg as needed for constipation, "unsupervised self-administration", and documented by staff as "U-SA" from 12/01/16 to 12/31/16. -An entry for Tramadol HCL 50 mg every 4 hours as needed for pain, "unsupervised self-administration", and documented by staff as "U-SA" from 12/01/16 to 12/31/16. Review of December 2016, January 2017, February 2017 and March 2017 MARs revealed that all medication were documented as "U-SA". Review of the "Self-Administration of Medications Review" completed by a nurse on 12/22/16 revealed documentation that Resident #6 was "fully capable" and could "correctly identify the expiration date of each medication". Review of a physician's order for Resident #6 presented on 3/16/17 revealed a telephone order dated 3/15/17 "may self administer own meds". Interviews on 3/15/17 at 9:50 am and 3/17/17 at 10:45 am with Resident #6 revealed: -He administered his own medications and kept them in a locked box in his dresser. -He was not aware if the staff had checked him administering his medications. -He was aware the names of his medications, what they were for, and when he was to take his medications. -He "only took 3 medications regularly, so it was cheaper to administer them to myself", and was the reason he requested to self-administer his medications.	D 375		

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D 375	Continued From page 37 -He "rarely took prn (as needed) medications". -He started to administer his own medications "sometime in December" 2016. -He was not aware his medication box contained expired medications or medications about to expire. He could not remember when he had last taken his Tramadol (from the card that expired 12/2016). -If he ran out of his medications, he notified the medication aides (MA), because they kept extra of his medications on the facility medication cart or they could order a refill. -The facility's pharmacy supplied his medications. Observation on 3/17/17 at 10:45 am of Resident #6's medications on hand with Resident #6 revealed: -Resident #6's medications were stored in a locked metal box in a dresser drawer, and was opened by a key kept in Resident #6's possession. -There was a punch card labeled pantoprotonix 40 mg daily. -There was a punch card labeled carpidop-levodopa 25-250 mg three times a day before meals. -There was a punch card labeled tamsulonsin HCL 0.4 mg daily. -There was a punch card labeled Senexon-S 8.6 mg prn constipation with an expiration date of 3/2017. -There was a punch card labeled Tylenol 325 mg to take 2 tablets every 6 hours as needed for pain or headache with an expiration date of 3/2017. -There were 2 punch cards labeled Tramadol 50 mg every 4 hours as needed for pain. One card was full and had expired 1/2017, the other card had 2 tablets missing and had expired 12/2016. Observation on 3/17/17 at 10:52 am of the extra	D 375		

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D 375	Continued From page 38 medications on hand for Resident #6 stored on the facility medication cart 1-2 revealed: -There was a full punch card for Resident #6 labeled carpidop-levodopa 25-250 mg three times a day before meals. -There were no other medications available for Resident #6. Interview on 3/17/17 at 10:52 am with a MA revealed: -Resident #6's extra supply of medications were kept on the facility medication cart. -She was not aware he had expired medications, but since he administered his own medications, she did not handle his medications. -She was not aware if the self-administration resident's medications were regularly monitored for expiration dates by the facility nurses or not. Interview on 3/17/17 at 11:30 am with the Resident Care Director (RCD) revealed she was not aware Resident #6 had expired medications in his room, but did not report who was responsible for monitoring expiration dates. Interview on 3/17/17 at 1:40 pm with the RN Case Manager revealed: -She was not aware Resident #6 had expired medications in his room, but they had already been removed to be returned to the pharmacy and medication refills had been ordered. -She did not report who what responsible for monitoring expiration dates. Refer to interview on 3/15/17 at 5:10 pm with the RCD. Refer to interview on 3/16/17 at 10:50 am and 11:44 am with the RN Case Manager.	D 375		

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BROOKDALE HIGH POINT	201 WEST HARTLEY DRIVE HIGH POINT, NC 27265

(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 375	Continued From page 39 Refer to interview on 3/16/17 at 6:23 pm with a second shift MA. Refer to interview on 3/17/17 at 1:20 pm with the District Administrator. C. Review of Resident #7's current FL 2 dated 2/09/17 revealed: -Diagnoses included seizure disorder, rectal cancer with colostomy, and osteoporosis. -There was no self-administer order on the FL 2. -A physician's order for acetaminophen 500 mg every 4 hours as needed (used to treat minor pain), Keppra 1000 mg twice a day (used to treat seizures), Evista 60 mg every morning (used to treat osteoporosis), and cyanocobalamin 1000mcg/ml injection monthly (used to treat and prevent a vitamin B12 deficiency). -Review of Resident #7's Resident Register revealed an admission date of 2/13/17. Review of Resident #7's record revealed: -Documentation in the "Resident Log" by the Registered Nurse (RN) dated 3/01/17 "self admin done and resident passed...care plan updated with changes". -A "Medication Review Report" dated 2/22/17 and signed by a physician on 2/24/17 that "medications are administered by the associates only". -A care plan dated 3/01/17 and signed by the physician on 3/08/17 documenting Resident #7 "passed a self administration of meds and will be giving her meds now". -A "Self-Administration of Medications Review" completed 3/01/17 by the RN and documented as the initial review. -There was no order in Resident #7's record to self-administer her medications prior to her	D 375		

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D 375	Continued From page 40 administering her own medications on 3/04/17. Review of a physician's order for Resident #7 presented on 3/17/17 revealed a telephone order dated 3/01/17 "may self administer own meds". It was not signed by a physician. Review of Resident #7's February 2017 Medication Administration Record (MAR) revealed: -The facility administered all medications to Resident #7 from 2/13/17 to 2/28/17. -An entry for cyanocobalamin 1000 mg subcutaneous injection every month and documented as administered at a previous facility. -An entry for Evista 60 mg daily and documented as administered daily at 8:00 am from 2/14/17 to 2/28/17. -An entry for levetiracetam (Keppra) 1000 mg twice a day and documented as administered at 8:00 am and 8:00 pm from 2/13/17 to 2/28/17. -An entry for mapap (Tylenol) 500 mg every 4 hours as needed for pain, and not documented as administered from 2/13/17 to 2/28/17. Review of Resident #7's March 2017 MAR on 3/17/17 revealed: -The facility administered all medications to Resident #7 from 2/01/17 to 3/03/17. -All medications were documented as "U-SA" (unknown-self-administered) from 3/04/17 to 3/31/17. -An entry for cyanocobalamin 1000 mg subcutaneous injection every month, "unsupervised self-administration", and documented as "U-SA" on 3/15/17. -An entry for Evista 60 mg daily, "unsupervised self-administration", and documented as "U-SA" daily at 8:00 am from 3/05/17 to 3/31/17.	D 375		

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D 375	Continued From page 41 -An entry for levetiracetam (Keppra) 1000 mg twice a day, "unsupervised self-administration", and documented as "U-SA" at 8:00 am and 8:00 pm from 3/04/17 to 3/31/17. -An entry for mapap (Tylenol) 500 mg every 4 hours as needed for pain, "unsupervised self-administration", and documented as "U-SA" from 3/04/17. Interview on 3/17/17 at 10:55 am with Resident #7 revealed: -The Case Manager nurse and the Resident Care Director (RCD) had assessed that her medications were locked up, that she could open the medication bottles, and that she was able to administer medications to herself. -She did not administer her (cyanocobalamin) injection to herself, but arranged to get it from her physician. She had not received her injection yet this month and needed to check with family member for when the appointment was. She needed to make sure she took it as she missed the dose last month since she was at another facility. She thought she would need to change physicians for the injection to be administered to her at the facility. -She felt safe taking her medications herself. Observation of Resident #7's medications on hand on 3/17/17 at 10:55 am with Resident #7 revealed: -Resident #7's medications were stored in a locked metal box on top of a dresser, and was opened by a key kept in Resident #7's possession. -The medications were in pill bottles with an easy to open lid. Resident #7 had no difficulty opening the bottles, and was aware what each medication was for and when it was to be taken. -A medication bottle labeled Keppra 1000mg	D 375		

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D 375	Continued From page 42 twice a day. -A medication bottle labeled Evista 60 mg daily. -An over the counter bottle of Tylenol 500 mg. The resident stated she could take it every 4 hours if she needed it. Interview on 3/17/17 at 11:35 am with Resident #7's family member revealed Resident #7 received her cyanocobalamin injections at the physician's office and monthly appointments had been made. Interview on 3/17/17 at 11:30 am with the RCD revealed: -Resident #7 received monthly injections from her physician. -Resident #7 and her family were in the process of making a decision about whether to change to the facility physician and get her injections from the Nurse Practitioner, or to continue with her physician from the previous facility. -The staff did not administer injections at this facility. Refer to interview on 3/15/17 at 5:10 pm with the RCD. Refer to interview on 3/16/17 at 10:50 am and 11:44 am with the RN Case Manager. Refer to interview on 3/16/17 at 6:23 pm with a second shift MA. Refer to interview on 3/17/17 at 1:20 pm with the District Administrator. D. Review of Resident #8's current FL 2 dated 10/19/16 revealed: -Diagnoses included hypothyroidism, anxiety disorder, chronic pain, muscle weakness,	D 375		

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D 375	Continued From page 43 hypertension, heart failure, gastro-esophageal reflux disease (gerd), osteoporosis and anemia. -A Nurse Practioner's (NP) order to "may self administer all medications". -Medication orders for aspirin 81 mg daily (a blood thinner), diltiazem extended release (ER) 180 mg daily (used to treat high blood pressure and chest pain), Lasix 40 mg daily (a diuretic), gabapentin 100 mg at bedtime (used to treat seizures and nerve pain), synthroid 50 mcg daily (a hormone to treat hypothyroidism), Remeron 15 mg at bedtime (an antidepressant), Zocor 20 mg at bedtime (used to treat high cholesterol), vitamin B12 1000 mg take 2 daily (a vitamin supplement), vitamin D3 1000 units daily (a vitamin supplement), colace 100 mg daily (a stool softener), ICAPs 1 tablespoon twice a day (a vitamin for the eyes), mapap 500 mg twice a day (used to treat mild to moderate pain), oyster shell calcium with vitamin D 500-200 daily (a supplement to treat osteoporosis), Aspercreme 4% lidocaine 4% apply to back topically 3 times a day for pain (used for topical pain relief), lidocaine 5% patch apply topically to area in the morning and remove at night daily as needed for pain (used for topical pain relief), Claritin 10 mg at bedtime as needed for allergies (an antihistamine). Review of Resident #8's Resident Register revealed an admission date of 11/27/13. Review of Resident #8's record revealed: -A care plan dated 3/17/16 and signed by the physician that Resident #8 did not need help with medications, and "self manages" her medications. -A Licensed Health Professional Support (LHPS) review dated 3/28/16 by a nurse that documented Resident #8 "self admin of meds with last	D 375		

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D 375	Continued From page 44 evaluation 1/22/16". -"Self-administration of medications review" assessments completed quarterly by a nurse dated 10/29/15, 1/22/16, 4/24/16, and 7/25/16. -There was no Self-Administration of Medications Review evaluation conducted from 7/25/16 through 3/17/17. Review of Resident #8's "Medication Review Report dated 12/21/16 and signed by the NP on 12/22/16 revealed: -An entry under "other: order summary" for "may self-administer medications. Medications may be kept in resident's room and taken without associate supervision" and documented as a prescriber written active order dated 6/17/16. -All the medications were as ordered on the FL 2 dated 10/19/16 except colace 100 mg was increased to twice a day. Review of Resident #8's March 2017 Medication Administration Record (MAR) revealed: -All medications were documented as "U-SA" (unknown-self-administered) from 3/01/17 to 3/31/17. -All medications were listed as per the FL2 dated 10/19/16 except the entry for colace 100 mg twice a day was correctly listed. Observation of Resident #8's medications on hand on 3/17/17 at 11:05 am with Resident #8 revealed: -Resident #8's medications were stored in a locked metal box on top of a dresser, and was opened by digital code entered by the resident. -The medications were in pill bottles that included over the counter (OTC) and medication bottles from a pharmacy. -There was a zip lock bag with 25 orange pills the resident identified as Advil (a non-steroidal	D 375		

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D 375	Continued From page 45 anti-inflammatory medication for pain control), which was not ordered. -Resident #8 had no difficulty opening the bottles, and was aware what each medication was for and when it was to be taken. -The medications in Resident #8's locked box included all the medications listed on her March 2017 MAR. -The medication box contained an OTC bottle of a multivitamin (a supplement), which was not ordered, an OTC bottle of Allegra (an antihistamine) which expired in May 2016 and was not currently ordered, a ProAir inhaler (used to treat wheezing and shortness of breath) which expired in May 2016 and was not currently ordered. -The Aspercreme was on Resident #8's bedside table. -Resident #8 gave the expired Allegra and the ProAir inhaler to her family member who was in the room. Interview on 3/17/17 at 11:05 am with Resident #8 revealed: -"A nurse used to check her medications every couple of months, but not in a long time." -She knew what medications she was taking, what they were for, and when to take the medications. -She was not aware she was ordered vitamin B12 2 tablets daily. She reported she took one tablet daily. -She was not aware the Advil tablets could not be in a plastic bag, and that she needed a physician's order to take them. She reported she had "not taken any (Advil) recently". -She was not aware she did not have an order to take her multivitamin. -She no longer took the Allegra, but was on Claritin. She was not aware it had expired.	D 375		

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D 375	Continued From page 46 -She no longer took her inhaler, and was not aware it had expired. -She felt safe to administer her own medications. Observation on 3/17/17 at 11:05 am of Resident #8 appeared that she was capable to self administer her medications. Interview on 3/17/17 at 11:15 am with Resident #8's family member who was in Resident #8's room revealed she had no concerns with Resident #8 self-administering her medications, and was not aware that medications needed to be in bottles and could not be in un-labeled plastic bags. Interview on 3/17/17 at 1:40 pm with the nurse Case Manager revealed: -She was not aware that Resident #8 had expired and discontinued medications in her room. -She was aware she had not recently completed a "Self-administration of medications review" of Resident #8. Refer to interview on 3/15/17 at 5:10 pm with the RCD. Refer to interview on 3/16/17 at 10:50 am and 11:44 am with the RN Case Manager. Refer to interview on 3/16/17 at 6:23 pm with a second shift MA. Refer to interview on 3/17/17 at 1:20 pm with the District Administrator. Interview with the Resident Care Director (RCD) on 3/15/17 at 5:10 pm revealed: -She was a Licensed Practical Nurse (LPN). -She had been in this position for about one	D 375		

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D 375	Continued From page 47 month and prior to that worked in a different facility owned by the same corporation. -Residents who self administer must be able to report what each medication was and how frequently and how much they took. -They all must have a physician's order to self-administer. -An assessment was done upon admission and every 3-4 months thereafter to determine competency for self-administration. -There were no checks to make sure the residents had an adequate supply of medications or if they were taking them correctly because they had no supervision once they were deemed competent. Interview on 3/16/17 at 10:50 am and 11:44 am with the nurse Case Manager revealed: -She was a Registered Nurse (RN) and had been the case manager for more than one year. -She had worked at the facility as the RN who completed the resident assessments, Licensed Health Professional Support (LHPS) reviews, self-administration reviews among other tasks, until last year 2016 when corporate changed her to a different role when another RN worked here. -The Health and Wellness Director (HWD) had been responsible for the self administration evaluations. -Residents that self-administered their medications had to keep them secured. -Residents that self-administered their medications were to be evaluated for competency every three months and typically when they returned from the hospital. -She thought she was caught up on the self-administration of medications assessments, and was aware they were to be completed quarterly. -It was not reported if the nurses were to review	D 375		

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D 375	Continued From page 48 the resident's actual medications when they performed a self-administration assessment. Interview with a Medication Aide (MA) on 3/16/17 at 6:23 pm revealed: -On the electronic MAR, "the resident names who self administer will come up green (blank) and no medications are listed. This indicates they are in the system but we do not administer their medications". -MA's were not responsible for checking with the residents who self administer their medications to ensure they had an adequate supply of medications. -If a resident reported being out of medications they would need to report to their family except the MAs would order medications for 2 of the residents that self-administer because they got their medications from the facility's contracted pharmacy. -If a resident had a change in condition "I would report the change to the RCD, the RN or the HWD". Interview on 3/17/17 at 1:20 pm with the District Administrator revealed: -The corporate policy was for an RN only to complete the self-administration review of residents. -Residents who self administered their own medications were to be evaluated for competency upon admission and quarterly. -Staff were responsible for routinely checking the rooms for medications that were not ordered by a physician, but it was not specified if specific staff were to check, or how often, or when the checks were completed.	D 375		

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D912	Continued From page 49	D912		
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 ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations regarding medications administered as ordered. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents (#9 and #10) observed during the medication passes, including Depakote (#10), and an antacid (#9), and 2 of 5 sampled residents (#2, #3) including a medication for an infection (#2, #3) and an anticoagulant (#2). [Refer to Tag 358, 10A NCAC 13F .1004 (a) (Type B Violation)]	D912		

The following is a summary of the Plan of Correction for Brookdale High Point. This Plan of Correction is in regards to the Corrective Action Report dates March 17, 2017. This Plan of Correction is not to be constructed as an admission of or agreement with the findings and conclusions in the State of Deficiencies, or any related sanction or fine. Rather, it is 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, nor have we identified mitigating factors.

10A NCAC 13F. 1004 Medication Administration

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.

- The Health and Wellness Director (HWD) will re-train Medication Technicians on the 6 rights of medication administration, to be completed by April 24, 2017. The Executive Director (ED)/HWD or Designee will conduct a medication pass observation on each medication aide to verify compliance with the 6 rights of medication administration. The ED/HWD or Designee will follow up on New Order Tracking forms to verify accuracy and proper transcription of physician orders twice per week while in the community. Plan of correction to be completed by April 30, 2017.

G.S. 131D-21 (2) Declaration of Residents' Rights
Each facility shall treat its residents in accordance with the provisions of this Article. Each resident shall have the following rights:
(2) To receive care and services which are adequate and appropriate and in compliance with relevant federal and state laws and rules and regulations.

- Appropriate associates were retrained regarding Resident Rights on 3-18-17.

The following is the Plan of Correction for the Brookdale High Point. This Plan of Correction is in regards to the Statement of Deficiencies resulting from the annual survey on 2-15-17. This Plan of Correction is not to be construed as an admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is 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.

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.

- A New Order Tracking Form will be utilized by associates for any new/changed orders.
- New Order Tracking Forms will be reviewed by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee daily when in the community for the next 30 days for completion of orders and appropriate follow through to include appropriate placement on the electronic MAR system with appropriate documentation.
- Thereafter, "New Order Tracking Forms" will be reviewed randomly, but at least on a weekly basis by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee to maintain appropriate follow-up is being completed by staff.
- Appropriate associates will be reeducated regarding the use of A New Order Track Form and order processing per policy, to include the addition to the Electronic MAR of all orders such as Labs by the Health and Wellness Director/Resident Care Coordinator.

10A NCAC 13F .1005 Self -Administration of Medications
(a) An adult care home shall permit residents
Who are competent and physically able to Self-administer their medications if the following Requirements are met
(1) The self-administration is ordered by a physician or other person legally authorized to Prescribe medications in North Carolina and documented in the resident's record; and

- An audit was completed regarding self-administration by the Health and Wellness Director/Resident Care Coordinator/Designee.
- Any discrepancies that were found, at that time, were followed up on with the physician for clarification as indicated.
- Appropriate associates will be re-educated regarding self-administration per policy.,
- Going forward the Executive Director/Health and Wellness Director/ Resident Care Coordinator/ Designee will do random observations of self-administration maintaining that proper handling is observed.