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
	HAL076007	A. BUILDING: _____ B. WING _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ASHEBORO	514 VISION DRIVE ASHEBORO, NC 27203

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 4-6, 2017.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure nectar thickened liquids for 1 of 3 sampled residents (#2) was prepared and served as ordered by the physician. The findings are: Review of Resident #2's current FL2 dated 10/24/16 revealed: -Diagnoses included pneumonia, dementia, poorly controlled type II diabetes mellitus, chronic renal insufficiency, and hyperglycemia. -There was no physician's order for nectar thick liquids on the FL2. Review of Resident #2's Resident Register revealed an admission date of 08/01/16 to the Assisted Living Unit. Review of Resident #2's Care Plan dated 08/11/16 revealed: -Resident #2 required limited assistance for eating and meal preparation.	D 310		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ED (X6) DATE 5/15/17

CMS 05/19/2017 Reviewed + Accepted

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D 310	Continued From page 1 Review of physician's orders for Resident #2 revealed an order for nectar thick liquids written on 10/18/16 prior to the current FL2 dated 10/24/16 Review of Resident #2's record revealed subsequent physician's orders dated 11/18/16 and 03/14/17 for nectar thick liquids. Review of Resident #2's Licensed Health Professional support review dated 02/17/17 revealed the resident had an order and was to be served nectar thick liquids. Review of the diet list posted in the kitchen on 04/04/17 revealed Resident #2 was to be served nectar thick liquids. Observation of dinner on 04/04/17 between 5:00 pm and 5:45 pm revealed: -Resident #2 was served eight ounces (oz) of regular consistency coffee and twelve oz of regular consistency water. -Resident #2 was served 12 oz of pre-thickened nectar thick cranberry juice. -Resident #2 was observed consuming the coffee and cranberry juice, but did not consume the water. -No coughing or choking was observed during the dinner meal. Interview on 04/04/17 at 5:20 pm with a second shift personal care aide (PCA) revealed: -Resident #2 was ordered nectar thick liquids. -Staff used a "scoop" of powdered thickener to thicken the liquids for the resident; not taking into account the amount of liquid served. -She had not received training on how to thicken Resident #2's beverages, but was verbally told by	D 310		

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D 310	Continued From page 2 other staff how to thicken liquids. Observation at breakfast on 04/05/17 between 8:00 am and 8:30 am revealed. -Resident #2 was served 12 oz of cranberry juice, but it did not appear to be thickened to nectar thick consistency. -Resident #2's milk in the cereal did not appear to be nectar thick consistency. -Resident #2 consumed all of the cereal and 75% of the milk served. -No coughing or choking was observed during the breakfast meal. Observation on 04/04/17 at 8:05 am of a first shift PCA revealed: -She demonstrated how she added the powder to the cranberry juice. She was using a 1 teaspoon scoop full per 12 oz of cranberry juice. -Per the container instructions, 12 oz of liquid called for 3 tablespoons to obtain nectar thick consistency. Interview on 04/05/17 at 8:07 am with a first shift PCA revealed: -She put "1 scoop" of powdered thickener in the "glass" for Resident #2's cranberry juice. -She was not aware of the size of the glass. -She was not aware of how to read the instructions on the back of the container for adding the powder to thicken liquids to the nectar thick consistency. -She did not thicken the milk in Resident #2's cereal and was not aware she was supposed to. Interview on 04/05/17 at 8:15 am with the Resident Care Coordinator (RCC) for the Special Care Unit (SCU) revealed: -Staff used all pre thickened liquids and had pre-thickened coffee powder packets to be mixed	D 310		

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D 310	Continued From page 3 with 6 oz of water. -All residents on thickened liquids were on nectar thick consistency -Pre-thickened nectar thick milk was available for the residents. Interview on 04/05/17 at 8:20 am with first shift PCA in the SCU revealed: -Staff used pre-thickened liquids if they were available . -If she had to use the powdered thickener, she would refer to the instructions on the back of the container at all times -She was trained on thickening liquids when hired and was employed with the facility for 6 years. Observation on 04/05/17 at 8:25 am of the kitchen revealed: -The pantry contained 5 containers of 48 oz pre-thickened iced tea, 5 containers of 48 oz pre-thickened water, 6 containers of 48 oz pre-thickened cranberry juice, 5 containers of 48 oz pre-thickened orange juice, 2 cases of 27 (8 oz) of pre-thickened milk, and 4 containers of 48 oz pre-thickened prune juice. All of the pre-thickened liquids available were of nectar thick consistency. There were coffee packets of nectar thick consistency available to be mixed with 6 oz of water. -A container of powdered thickener was on the countertop in the kitchen. Review of the instructions on the container of thickener revealed: -To obtain nectar consistency in 4 oz of beverages use 1 tablespoon. -To obtain nectar consistency in 6 oz of beverages use 1 and 1/2 tablespoons -To obtain nectar consistency in 8 oz of beverages use 2 tablespoons.	D 310		

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D 310	Continued From page 4 -To obtain nectar consistency in 12 oz of beverages use 3 tablespoons. -There was a scoop with two ends; the small scoop measured a teaspoon and the big scoop measured a tablespoon. Interview with Resident #2's Primary Care Provider on 04/06/17 at 11:10 am was unsuccessful. Based on observations, record review and interviews with staff, it was determined Resident #2 was not interviewable. Interview on 04/06/17 at 11:20 am with the Food Service Manager revealed: -The diet list was prepared by staff in the office. -He was not the Dietary Manager but the Food Service Manager. -He educated and instructed staff on safe serve. -He did not have any part of educating new or existing employees on the thickening of liquids. -The Health and Wellness Director educated all new staff on the process of thickening liquids. -He had been to Culinary School and was trained in food service by the facility -He was aware Resident #2 was on thickened liquids and he was aware of the consistency ordered. -Dietary staff do not prepare thickened liquids for Resident #2. The PCAs thickened the liquids. -There had been a lot of turn over with the PCAs and by the time they get trained they would leave. He felt this may have been the cause of lack of communication and knowledge with preparing thickened liquids. -He was not aware of how to prepare thickened liquids, but was aware the directions were on the back of the container of powdered thickener. -He was aware there were pre-thickened nectar	D 310		

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D 310	Continued From page 5 thick liquids available to residents with physician's orders for thickened liquids. Interview on 04/06/17 at 3:15 pm with the Health and Wellness Director revealed: -Resident #2 had recently been ordered thickened liquids. -She was responsible for training staff on thickened liquids when staff were initially hired. -Additional training was available if needed or if staff requested training. -Training was available if it was noticed staff needed additional education.	D 310		
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, record reviews, and interviews, the facility failed to assure medications (alendronate, vitamin D3, Novolog insulin and Tylenol) were administered as ordered by a licensed prescribing practitioner for 3 of 4 residents observed during a medication pass (#2, #7, and #8), and 2 of 5 sampled residents (#1 and #2).	D 358		

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D 358	Continued From page 6 The findings are A. The medication pass error rate was 5% as evidenced by 3 medication errors observed out of 41 observations. 1. Review of Resident #8's current FL2 dated 04/21/16 revealed diagnoses included dementia, hypertension and degenerative joint disease (DJD). Review of Resident 8's record revealed an order dated 07/18/16 and signed physician's orders dated 12/20/16 ordering alendronate 70 mg (used to prevent and treat certain kinds of bone loss) one time a day on every Wednesday related to "OTHER ARTHRITIS". (The manufacturer's recommendations for alendronate were to take this medication after getting up for the day and before the first food, beverage, or other medication. Drink at least 2 ounces (60 milliliters) of plain water, stay fully upright (sitting, standing, or walking) for at least 30 minutes. Alendronate works only if taken on an empty stomach. Wait at least 30 minutes (preferably 1 to 2 hours) after taking the medication before you eat or drink anything other than plain water.) Observation of the morning medication pass on 04/05/17 at 7:58 am revealed: -Resident #8 was observed at the medication cart outside the small dining room on the 300 Hall. -The 300 Hall medication aide (MA) prepared 12 oral medications for Resident #8. -The medications included alendronate 70 mg. -Just after the alendronate was administered, the resident moved into the small dining room. -At 8:10 am, the resident was observed eating a bowl of cereal with milk, and drinking coffee	D 358		

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D 358	Continued From page 7 Observation on 04/05/17 at 8:00 am of the manufacturer's packaged medication box for alendronate 70 mg labeled for Resident #8 and dispensed on 03/08/17 for a quantity of 4 tablets revealed: -The label stated "give 1 tab orally weekly with 8 ounces of water, 30 minutes before all food/medications, stay upright". -An auxiliary label was affixed to package stating "swallow whole-don't chew/crush 30 minutes before 1st food/beverage/medications. Take with 8 ounces of plain water. Avoid lying down X 30 minutes after " Review of Resident #8's printed electronic medication administration record (eMARs) for March 2017 and April 2017 revealed: -An entry for Alendronate 70 mg give one table one time a day on every Wednesday related to "OTHER ARTHRITIS" and scheduled weekly at 8:00 am. -Administration was documented at 8:00 am on 03/01, 03/08, 03/15, 03/22, 03/29, and 04/05 Interview at 8:00 am on 04/05/17 with the medication aide (MA) on the 300 Hall revealed: -The residents routinely ate breakfast at 8:00 am daily. -The residents' medications were administered according to the eMAR. -Medications appeared on the eMAR one hour before up to one hour after the scheduled time for administration. -Resident #8's routinely received all the medications appearing on the eMAR for the 8:00 am morning medication pass at the same time. -She administered alendronate 70 mg at 8:00 am because that was the time it appeared on the eMAR for administration.	D 358		

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D 358	Continued From page 8 -Resident #8 liked to receive her medications just before she ate. Second interview on 04/05/17 at 12:40 pm with the 300 Hall MA revealed: -She had worked at the facility for 5 to 6 years. -The facility had been using electronic medication administration records (eMAR) since July 2016. -Resident #8's alendronate 70 mg was scheduled at 6:30 am on the paper MAR. -When the medications were entered into the eMAR system by the Facility Nurse (FN) or Resident Care Coordinator (RCC), alendronate 70 mg started appearing at 8:00 am, along with the resident's other morning medications. -She was aware the package for Resident #8's alendronate had information regarding administering the medication 30 minutes prior to other medications and the resident not laying down for 30 minutes. -She had not informed the FN or RCC about the scheduled time of the alendronate. Based on record review, observations, and staff interviews it was determined Resident #8 was unable to provide reliable information. Telephone interview on 04/05/17 at 2:33 pm with the Corporate Nurse revealed: -She was not aware Resident #8's alendronate 70 mg was scheduled along with other medications at 8:00 am. -She would expect MA staff to read the directions on the medication package as well as the eMAR to administer the alendronate correctly. Telephone interview on 04/06/17 at 2:25 pm with the prescribing practitioner revealed: -Alendronate 70 mg should be administered by the guidelines and manufacturer's	D 358		

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D 358	Continued From page 9 recommendations for the medication. -He was not aware Resident #8 received alendronate along with her other medications. Refer to interview on 04/05/17 at 1:05 pm with the Facility Nurse (FN). Refer to telephone interview on 04/05/17 at 2:33 pm with the Corporate Nurse. 2. Review of Resident #7's current FL2 dated 05/19/16 revealed diagnoses polymyalgia, hyperlipidemia, hyponatremia, osteopenia. Review of Resident 7's record revealed: -An order dated 02/02/17 for calcium (a vitamin supplement used to treat calcium deficiency) 500 mg 3 tablets every day. -An order for vitamin D3 (used to increase the absorption of calcium) 2000 international units (IU) daily. Observation of the morning medication pass on 04/05/17 at 8:30 am revealed: -Resident #7 was observed in her room on the 100 Hall -The 100 hall medication aide (MA) prepared 13 oral medications for Resident #7. -Vitamin D3 2000 IU was not included in the medications received by Resident #8 at 8:42 am. Interview on 04/05/17 at 8:35 am with the 100 Hall medication aide (MA) revealed: -She had been administering medications at the facility for just over a month. -The MA stated Resident #7 did not have vitamin D3 2000 IU on the medication cart to prepare for Resident #7. -Resident #7 had at least one vitamin D3 2000 when she administered the resident's medication	D 358		

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D 358	Continued From page 10 yesterday (04/04/17). -She was sure she reordered vitamin D3 2000 IU yesterday, and the medication should have come from the pharmacy last night. -She would look for the vitamin D3 2000 IU and inform the surveyor when the medication was available to be administered. -She was not sure what procedure to follow if a resident did not have a medication on the medication cart or in the backup stock. Interview on 04/05/17 at 8:36 am with Resident #7 revealed. -She received her medications about the same time every day. -She took a lot of medications and did not the name of all her medications. -She did not count the medications she received. -Medication aide staff managed her medication for her. Interview on 04/05/17 at 3:00 pm revealed the 100 Hall MA did not administer Resident #7's vitamin D3 2000 IU before her shift ended at 3:00 pm on 04/05/17. Interview on 04/05/17 at 1:45 pm with the 300 Hall MA revealed the facility's policy for medications not on the medication cart for administration was as follows: -The MA should check the backup stock for the resident. -The MA should call the pharmacy provider to find out why the medication was not sent if reordered. -As a last resort, the MA should try to get the medication from the backup pharmacy for a supply to last until the resident's order came from the pharmacy provider. -If the medication was not available, the MA should fill out a missed medication report, notify	D 358		

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D 358	Continued From page 11 the RCC or FN, and notify the prescriber. Review of Resident #7's electronic medication administration records (eMARs) for April 2017 revealed an entry for vitamin D3 2000 IU give one tablet one time a day for vitamin insufficiency and documented as not administered on 04/05/17 with "not available" for the reason. Based on record review, observations, and staff interviews it was determined Resident #7 was unable to provide reliable information. Interview on 04/05/17 at 1:25 pm with the Facility Nurse (FN) revealed: -Medications aides were responsible to stock the medication carts with residents' medications when the facility received the medications from the contracted pharmacy. -If a resident was missing a medication during the medication pass, the MA should check the overstock in the bottom of the medication cart, the pharmacy delivery totes in the medication cart storage area, call the pharmacy to check on the status of the medication reorder, or as a last resort obtain the medication from the backup pharmacy. -The MAs should not have a resident's medication marked as not available for administration. -Resident #7's vitamin D3 2000 IU could have been obtained from the back-up pharmacy. Refer to interview on 04/05/17 at 1:05 pm with the Facility Nurse (FN). Refer to telephone interview on 04/05/17 at 2:33 pm with the Corporate Nurse. 3. Review of Resident #2's current FL2 dated	D 358		

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D 358	Continued From page 12 10/24/16 revealed: -Diagnoses included dementia, poorly controlled type 2 diabetes and hyperglycemia. -An order for Lantus (a long acting insulin) insulin 30 units subcutaneously daily. Review of Resident #2's record revealed a physician's order dated 10/01/16 as follows: -Fingerstick blood sugar (FSBS) before meals and at bedtime. -Humalog (a rapid acting insulin) insulin before meals and at bedtime per sliding scale. -The sliding scale insulin (SSI) parameters were ordered as follows: less than 200= 0 units, 201-250=4 units, 251-300= 6 units, 301-350= 8 units, and greater than 351=10 units. A subsequent signed physician's order dated 03/01/17 revealed Novolog (a rapid acting insulin) insulin inject as per sliding scale as follows: sliding scale less than 200= 0 units, 201-250=4 units, 251-300= 6 units, 301-350= 8 units, and greater than 351=10 units, before meals and at bedtime related to Type 2 Diabetes Mellitus. Check FSBS before meals and at bedtime. Observation on 04/05/17 at 7.22 am revealed Resident #2 was seated at a table in the dining room. There was no food on the table. Interviews on 04/05/17 at 7:45 am and 8:25 am with the 100 Hall medication aide revealed: -She had been working on the medication cart for a little more than one month. -Resident #2 had already gone to the dining room before she had a chance to take her FSBS and administer any insulin -The facility policy was to not administer medications to residents in the dining room.	D 358		

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D 358	Continued From page 13 -She was not sure what to do about Resident #2's FSBS since it was supposed to be done before breakfast -She would check Resident #2's FSBS, and administer SSI, when the resident came out of the dining room. Observation on 04/05/17 at 8:40 am revealed: -Resident #2 made her way from the dining room to her. -Resident #2 had eaten breakfast. Observation on 04/05/17 at 9:10 am of medication administration on the 100 Hall revealed: -The MA performed a FSBS check for Resident #2 with a reading of 238. -The MA prepared 4 units of Novolog insulin and injected subcutaneously into the resident's left lower abdomen. Interview on 04/05/17 at 9:15 am with Resident #2 revealed: -Staff routinely administered her medications including insulin. -She received her insulin after she received her FSBS check depending on the value of the FSBS. -She received insulin before her meals most of the time. -She went to breakfast today before her insulin shot. Telephone interview on 04/05/17 at 2:33 pm with the Corporate Nurse revealed: -Medication aides (MAs) received training on performing fingerstick blood sugar checks and insulin administration during their medication aide check off. -MAs received annual training on diabetes,	D 358		

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	HAL076007	A. BUILDING: _____ B. WING _____	04/06/2017

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D 358	Continued From page 14 including insulin administration from the contracted pharmacy. -MA training on insulin included the length of time before the various insulin types take effect. -Rapid acting insulin ordered before meals should be administered no more than 15 to 30 minutes before the resident starting eating. -MAs would be expected to administer insulin according to the order on the eMAR. -No medication aide staff had informed her that residents were receiving rapid acting insulins after meals. Telephone interview on 04/06/17 at 2:25 pm with Resident #2's primary care physician revealed: -He was not aware facility staff was administering sliding scale insulin without regard to meal time. -He would expect the facility to administer Novolog sliding scale insulin close (within 15 to 30 minutes) of a meal using the insulin guideline for administration. -He suggested the facility staff receive training on the proper times for insulin administration. -The one hour before or after scheduled time of administration did not apply to all medications, including insulin. Refer to interview on 04/05/17 at 1:05 pm with the Facility Nurse (FN). Refer to telephone interview on 04/05/17 at 2:33 pm with the Corporate Nurse B. Review of Resident #2's current FL2 dated 10/24/16 revealed: -Diagnoses included dementia, poorly controlled type 2 diabetes and hyperglycemia. -An order for Lantus(a long acting insulin) Insulin 30 units subcutaneously daily.	D 358		

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D 358	Continued From page 15 Review of Resident #2's record revealed a physician's order dated 10/01/16 as follows: -Fingerstick blood sugar (FSBS) before meals and at bedtime -Humalog (a rapid acting insulin) insulin before meals and at bedtime per sliding scale per sliding scale less than 200= 0 units, 201-250=4 units, 251-300= 6 units, 301-350= 8 units, and greater than 351=10 units. Review of Resident #2 record revealed: -A subsequent signed physician's order dated 03/01/17 for Novolog (a rapid acting insulin) insulin inject as per sliding scale as follows: sliding scale less than 200= 0 units, 201-250=4 units, 251-300= 6 units, 301-350= 8 units, and greater than 351=10 units, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus. -An order dated 03/01/17 to check FSBS before meals and at bedtime. Review of Resident #2's March 2017 electronic medication administration record (eMAR) revealed: -An entry for Novolog insulin inject as per sliding scale as follows: less than 200= 0 units, 201-250=4 units, 251-300= 6 units, 301-350= 8 units, and greater than 351=10 units, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus. Check FSBS before meals and at bedtime was listed on the eMAR. -Check FSBS and administer Novolog SSI was scheduled at 8:00 am, 11:00 am, 1600 (4:00 pm), at 1900 (7:00 pm) daily. -FSBS results were documented 122 times for 124 opportunities. -Novolog SSI should not have been administered at 8:00 am based on 31 FSBS values compared	D 358		

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D 358	Continued From page 16 to the SSI parameters. -Novolog SSI should have been administered, based on FSBS values for the scheduled 11:00 am FSBS, 19 times according to the SSI parameters. -Novolog SSI was documented as administered more than 30 minutes prior to the 12:00 pm (noon) meal for 11 of 19 opportunities. Examples included: on 03/01 FSBS=297 with 6 units administered at 11:20 am, on 03/02 FSBS=324 with 8 units administered at 11:13 am, on 03/08 FSBS=269 with 6 units administered at 10:42 am, on 03/09 FSBS=254 with 6 units administered at 10:54 am, on 03/20 FSBS=228 with 4 units administered at 10:42 am, and 03/27 FSBS=290 with 6 units administered at 10:56 am. -Novolog SSI should have been administered, based on FSBS values for the scheduled 4:00 pm FSBS, 19 times according to the SSI parameters. -Novolog SSI was documented as administered more than 30 minutes prior to the 5:00 pm meal for 16 of 19 opportunities. The values were as follows: on 03/02 FSBS=305 with 8 units administered at 3:37 pm, on 03/05 FSBS=239 with 4 units administered at 4:04 pm, on 03/09 FSBS=219 with 4 units administered at 3:39 pm, on 03/13 FSBS=261 with 6 units administered at 3:25 pm, on 03/22 FSBS=286 with 6 units administered at 4:19 pm, and 03/31 FSBS=251 with 6 units administered at 3:25 pm. Interview on 04/05/17 at 9:15 am with Resident #2 revealed. -Staff routinely administered her medications including insulin. -She received her insulin after she received her FSBS check depending on the value of the FSBS. -She received insulin before her meals most of the time.	D 358		

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D 358	Continued From page 17 -She had not felt that her blood sugar was too low in a long time, most of the time it was high when the staff checked it. Telephone interview on 04/05/17 at 2:33 pm with the Corporate Nurse revealed: -Medication aides (MAs) received training on performing fingerstick blood sugar checks and insulin administration during their medication aide check off. -MAs received annual training on diabetes, including insulin administration from the pharmacy provider -MA training on insulin included the length of time before the various insulin types starting working -Rapid acting insulin ordered before meals should be administered no more than 15 to 30 minutes before the resident starting eating. -MAs would be expected to administer insulin according to the order on the eMAR. -No medication aide staff had informed her that residents were receiving rapid acting insulins after meals. Telephone interview on 04/06/17 at 2:25 pm with Resident #2's primary care physician revealed: -He was not aware facility staff was administering sliding scale insulin without regard to meal time. -He would expect the facility to administer Novolog sliding scale insulin close (within 15 to 30 minutes) of a meal using the insulin guideline for administration -He suggested the facility staff receive training on the proper times for insulin administration. -The one hour before or after scheduled time of administration did not apply to all medications, including insulin. Interview on 4/06/17 at 3:00 pm with an evening shift Medication Aide/Supervisor (MAS) revealed:	D 358		

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D 358	Continued From page 18 -The residents routinely were served dinner starting around 5:00 pm daily. -She had received training on the administration of insulin within the last year -The training included the various insulin types and how quickly insulins started working including the rapid acting insulin working within 15 to 30 minutes -She administered SSI to Resident #2 in the evening when she worked the 100 Hall medication cart. -She was aware Resident #2 had Novolog SSI ordered before dinner -Medications scheduled for administration at 11:00 am would start appearing on the eMAR monitor at 10:00 am and appear until 12:00 pm for administration. -Medication scheduled for administration at 4:00 pm would appear on the eMAR monitor between 3:00 pm and 5:00 pm for administration. -Resident #2's scheduled 4:00 pm order for FSBS and Novolog SSI started appearing on the eMAR monitor at 3:00 pm. -She was aware she should wait until 15 to 30 minutes before a meal to administer Novolog SSI insulin to Resident #2. -She routinely started administering 4:00 pm medications at 3:00 pm because she helped with food service to residents starting around 4:45 pm and she needed to be finished with the medication pass. -She gave Resident #2's Novolog SSI because it was appearing on the eMAR starting at 3:00 pm. -The times should be adjusted on the eMAR to schedule the Novolog SSI to appear after 4:00 pm. Refer to interview on 04/05/17 at 1:05 pm with the Facility Nurse (FN)	D 358		

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D 358	Continued From page 19 Refer to telephone interview on 04/05/17 at 2:33 pm with the Corporate Nurse. C. Review of Resident #1's current FL2 dated 10/24/16 revealed diagnoses included late onset Alzheimer's disease with behavioral disturbance, and ambulatory dysfunction. Review of Resident #1's record revealed a physician's order dated 02/14/17 for Tylenol (used to treat pain and/or fever) 325 mg two tablets every 6 hours for pain. Review of Resident #1's February 2017, March 2017, and April 2017 electronic Medication Administration Record (eMAR) revealed: -Tylenol 325 mg two tablets every 6 hours for pain was not listed on the printed eMARs. -An entry for Tylenol 325 mg two tablets every 6 hours "as needed" for pain was listed -Tylenol 325 mg had no scheduled times for administration listed. -Tylenol 325 mg was documented for administration and effective on the February 2017 eMAR as follows: On 02/14/17 at 3:38 pm, on 02/15 at 3:28 pm, on 3/18 at 3:29 pm, and on 02/23 at 11:51 pm. -Tylenol 325 mg was not documented for administration for March 2017. -Tylenol 325 mg was not documented for administration for April 2017 Observation on 04/06/17 at 12:50 pm of Resident #1's medication on hand for administration revealed the resident had 198 tablets (3 bingo cards with 60 tablets plus one bingo card with 18 tablets) of Tylenol 325 mg labeled 2 tablets every 6 hours for pain remaining from a supply of dispensed on 02/14/17 for 240 tablets.	D 358		

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D 358	Continued From page 20 Interview on 04/06/17 at 12:55 pm with a medication aide (MA) revealed: -The resident's order were entered into the eMAR system by the Facility Nurse (FN) or the Resident Care Coordinator (RCC). -She did not believe Resident #1 would be able to tell a MA that he was in pain due to his mental status. -Resident #1 moved around the Special Care Unit with a walker. -Resident #1 slept a lot. -If Resident #1 sat and held his knees, that would be a sign he was hurting. -She had not observed Resident #1 sitting and holding his knees in the last month. Interview on 04/06/17 at 12:58 pm with a personal care aide (PCA) revealed: -Resident #1 had been sitting around and holding his knees when he was first prescribed the Tylenol for pain. -She had not observed his sitting and holding his knees recently. -The PCA stated the resident "does not look like in pain" now like he used to. Interview on 04/06/17 at 2:30 pm with the RCC revealed: -She entered the order written on 02/14/17 for Resident #1's Tylenol 325 mg 2 tablets every 6 hours for pain into the eMAR computer system. -She had incorrectly entered the order for "as needed" instead of scheduled every 6 hours. -MA staff administered the medications as ordered on the eMAR -She would correct the order in the eMAR computer system and inform Resident #1's primary care physician of the medication error. Telephone interview on 04/06/17 at 2:40 pm with	D 358		

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D 358	Continued From page 21 Resident #1's primary care physician revealed: -Tylenol 325 mg 2 tablets every 6 hours for pain was ordered to be given routinely. -He had discussed the resident's declining mental status with a representative of the family and decided the resident might not be able to communicate his need for an "as needed" dosing of the Tylenol. -He felt Resident #1 would benefit from the pain relieving effect of the Tylenol due to his arthritis. Telephone interview on 04/06/17 at 4:20 pm with the pharmacy provider revealed: -The pharmacy received a copy of the order dated 02/14/17 for Resident #1's Tylenol 325 mg take 2 tablets every 6 hours for pain -The pharmacy dispensed a quantity of 240 tablets on 02/14/17 and had no record for a refill of the medication. -The pharmacy tracked medications orders for the residents at the facility and provided medication and refills when the facility reordered the medication. -The pharmacy was not contracted to enter orders into the facility's eMAR computer but did have a program that interfaced with the eMAR system of the facility for monitoring resident medication orders and profiles. -The eMAR system must have an order that the facility had entered incorrectly if the eMAR was showing Resident #1's Tylenol 325 mg for "as needed" instead of scheduled. Based on record review, and observation of Resident #1 on 04/04/17, it was determined the resident was not interviewable. Refer to interview on 04/05/17 at 1:05 pm with the Facility Nurse (FN).	D 358		

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D 358	Continued From page 22 Refer to telephone interview on 04/05/17 at 2:33 pm with the Corporate Nurse. Interview on 04/05/17 at 1:05 pm with the Facility Nurse (FN) revealed: -A weekly eMAR audit was performed by FN, the Resident Care Coordinator (RCC), and a medication aide/Supervisor that focused on assuring documentation of medication administration was complete (no empty documentation spaces on the eMAR). -The facility had used paper MARs until about 6 months ago. -The facility used a "medication tracking form" to assure medications were entered on the eMAR. -The FN, RCC, would be responsible to assure medications were transcribed correctly to the eMAR, including the times for administration assigned to the medications. -Medication aides were responsible to administer medications as ordered during the medication pass. Telephone interview on 04/05/17 at 2:33 pm with the Corporate Nurse revealed -She was onsite at the facility weekly and available for phone consultation at any time -She did random record audits, including medication audits, when she came to the facility. -The facility changed to eMAR from the paper MAR a few months ago. -Staff (FN and RCC) at the facility had entered all the orders for the medications at the transition. -The eMAR computer system assigned times for administration based the frequency a medications was prescribed. -The staff entering the order should manually override the computer's assigned times if needed. -MA staff should be reading each medication order displayed on the eMAR computer as well as	D 358		

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D 358	Continued From page 23 relying on the eMAR system to display medications due for administration within the one hour before up to one after the scheduled time -She was not aware of any specific medication that was not being administered as ordered. The facility failed to assure medications (alendronate, vitamin D3, Novolog insulin and Tylenol) were administered as ordered by a licensed prescribing practitioner for 3 of 4 residents observed during a medication pass (#2, #7, and #8), and 2 of 5 sampled residents (#1, and #2). Resident #8 received a medication (alendronate 70 mg) for treating bone loss along with other medications at mealtime when it should be administered by itself 30 minutes before food, or other medications which could lead to the medication not being effective and further loss of bone mass. Resident #7 did not receive a medication (vitamin D3 2000 IU) as ordered during medication administration on 04/05/17 which could lead to decreased calcium absorption and bone mass loss. Resident #2 received a rapid-acting insulin 50 minutes after breakfast on 04/05/17, when it was ordered before meals, and at various times as much as 1 hour and 35 minutes before meals in March 2017 which could lead to episodes of hypoglycemia (low blood sugar). Resident #1 did not receive a pain medication (Tylenol 325 mg) scheduled as ordered which could result in increased pain and discomfort. The failure of the facility to administer medications as ordered was detrimental to the health and safety of the residents and constitutes a Type B Violation. Review of the Plan of Correction provided by the facility on 04/06/17 revealed: -The facility will review resident's records to assure medication orders and the electronic	D 358		

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D 358	Continued From page 24 Medication Administration Records (eMARs) and match for medications and times scheduled for administration -The facility will in-service staff concerning any medications that might have dosing parameters. -Compliance will be monitored by the Executive Director (ED), Health and Wellness Director (HWD) and Resident Care Coordinator (RCC) on a weekly basis for one month. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 21, 2017.	D 358		
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 medication administration. The findings are: Based on observations, record reviews, and interviews, the facility failed to assure medications (alendronate, vitamin D3, Novolog insulin and Tylenol) were administered as ordered by a licensed prescribing practitioner for 3 of 4	D912		

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D912	Continued From page 25 residents observed during a medication pass (#2, #7, and #8), and 2 of 5 sampled residents (#1, and #2). [Refer to Tag 0358, 10A NCAC 13F 1004(a) Medication Administration (Type B Violation)].	D912		

May 15, 2017

DHHS/DHSR
Adult Care Licensure Section
2708 Mail Service Center
Raleigh, N.C. 27699-2708

Please find enclosed Brookdale Asheboro's Plan of Correction in response to the Annual survey completed on April 6, 2017 (ASPEN Event ID 3I6411).

Please do not hesitate to contact me if there any any questions or concerns.

Regards,

Victoria Pharo E.D.
Brookdale Asheboro
514 Vision Dr.
Asheboro, N.C. 27203

The following is a summary of the Plan of Correction for Brookdale Asheboro. This Plan of Correction is in regards to the Corrective Action Report dated April 25, 2017. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is 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 13G .0904 Nutrition and Food Service
(e) Therapeutic Diets in Family Care Homes:
4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

- Therapeutic diets will be followed as ordered by the physician, and per policy, to include accurate thickened liquids.
- Associates will be re-educated on the preparation of thickened liquids as ordered, to include return demonstrations. This training will be completed by the RN Case Manager/Resident Care Coordinator/Executive Director no later than May 20, 2017.
- Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee will complete daily observations at each meal they are present for, for three weeks for thickened liquid accuracy, and then random observations, but at least 2 times weekly, for compliance thereafter.

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 policies and procedures.

- An audit was completed regarding having medications on hand to match the current orders by the Executive Director/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 or administration times were corrected in the electronic MAR.
- Associates were retrained regarding the 7 Rights of Medication Administration per policy, to include administration of Insulin, by the Executive Director/Health and Wellness Director/Resident Care Coordinator./Designee.
- Medication orders received will be reviewed by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee daily for the next 30 days, when in the community, reviewing administration times.
- There after a "New Order Tracking" form will be utilized as indicated, to include transcription of orders with accurate medication administration times, by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee at least on a weekly basis.

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 and administration of medications as ordered.