STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 11/23/2016

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BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 11/22/16 and 11/23/16.	{D 000}		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 1 of 5 sampled residents (Resident #5) who had orders for physical, occupational and speech therapy. The findings are: A. Review of Resident #5's current FL2 dated 10/25/16 revealed: -Diagnosis included dementia, acute renal failure, hypothyroidism and "gastro-esophageal". -The FL2 included orders for speech therapy (ST), occupational therapy (OT) and physical therapy (PT) 5 times per week. Review of Resident #5's Resident Register revealed she was admitted to the facility on 10/27/16 from a local rehabilitation center. Review of Resident #5's Home Health Physical Therapy notes revealed: -A physician's order for home health physical therapy was received on 11/02/16 to establish a plan and evaluate and treat. -The home health agency requested and received	D 273		

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ADULT CARE
LICENSURE SECTION
RALEIGH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director 12/28/16

Reviewed + Accepted 1-6-17 gk

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D 273	Continued From page 1 a physician's order to defer the PT consult on 11/04/16 until 11/07/16. -The PT evaluation occurred on 11/07/16. Review of the Occupational Therapy notes revealed OT initated care on 11/15/16. Interview with a representative from the home health agency on 11/22/16 at 3:04 pm revealed: -Initially, PT was ordered on 11/02/16 and they obtained a physician's order to defer the start of treatment until 11/07/16. -The home health agency received an add-on order for OT on 11/11/16 and they evaluated Resident #5 on 11/15/16. -The physical therapist that did the initial evaluation would have been the one that obtained the orders from Resident #5's physician. -Once they received an order for any kind of therapy they were expected to initiate therapy within 48 hours. -The hoe health agency did not have an order for ST. Interview with a second representative from the home health agency on 11/22/16 at 5:15 pm revealed: -She served as a liaison between the home health agency and the facility. -She would gather information from the resident's record and facilitate the start of therapy. -The home health company did not consider PT, OT or ST orders that were on the FL2 to be actual physician orders. -The FL2s often had orders for therapies that the residents did not actually need. -She would decide what discipline was needed by the resident, and obtain an order from the facility's nurse practitioner. -If the therapist visiting the resident thought that	D 273		

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D 273	Continued From page 2 another discipline was needed for the resident they would obtain an order from the nurse practitioner. -She did not know who decided Resident #5 did not need ST, but when the physical therapist thought OT would benefit the resident they obtained an order and initiated this therapy. -If the home health agent that performed the initial evaluation identified Resident #5 with a swallowing problem they would have obtained an order for ST. -The home health agency did not get an order to discontinue ST because they did not identify ST on the FL2 as an order. Interview with Resident #5's Responsible Party (RP) on 11/23/16 at 10:35 am revealed: -Resident #5 began to present with swallowing problems approximately 5 years ago. -Resident #5 did have difficulty eating and had been hospitalized twice for electrolyte imbalance secondary to insufficient intake. -Resident #5 had a history of aspiration pneumonia. -She was aware that PT, OT and ST were ordered when Resident #5 was discharged from her rehabilitation facility. -She thought Resident #5 was taking speech therapy. -She thought Resident #5 really needed speech therapy given her history and progressive Lewy Body Disease. Interview with a Medication Aide (MA) on 11/22/16 at 3:50 pm revealed: -Therapy ordered on the FL2s were faxed to the home health agency. -A representative from the home health agency would come out at least weekly and process the therapy orders.	D 273		

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D 273	Continued From page 3 -There was no process in place to verify the therapy orders on the FL2 were initated. Interview with the former Resident Care Coordinator (RCC) on 11/23/16 at 9:52 am revealed: -She faxed the FL2 to the home health agency when admitting Resident #5 to the facility. -She understood the OT, PT and ST 5 times a week on the FL2 were orders to be initiated by the home health agency. -After she faxed the FL2 the representative from the home health agency would come to the facility and "do the paper work and take care of everything". -There was no process in place to verify the therapy orders on the FL2 were initated. Interview with a Health and Wellness Director (HWD) on 11/22/16 at 4:08 pm revealed: -The former RCC should have faxed the FL2 to the home health agency so they could initiate services. -They did have the home health agency start PT services. -She did not know ST was ordered or why ST was not initiated. -She did consider the therapy orders on the FL2 to be physician orders. -She did not know why the home health agency did not consider the therapy orders on the FL2 to be physician orders. Interview with the Administrator on 11/22/16 at 9:00 am revealed: -She was not aware Resident #5 had orders for OT that were initiated 3 weeks after they were ordered. -She did not know ST was ordered or why ST was not initiated.	D 273		

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D 273	Continued From page 4 -She did consider the therapy orders on the FL2 to be physician orders. -She did not know why the home health agency did not consider the therapy orders on the FL2 to be physician orders. Based on record review, observations and interviews it was determined Resident #5 was not interviewable.	D 273		
{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 record review, observation and interview the facility failed to assure implementation of Thrombo-Embolic Deterrent (TED) hose on in the morning and off at bedtime and to obtain daily and weekly blood pressures for 3 of 5 sampled residents (Residents #2, #4, and #5). The findings are: A. Review of Resident #4's current FL2 dated 07/19/16 revealed: -Diagnoses included dementia, hypertension, chronic kidney disease stage 2, and low back	{D 276}		

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{D 276}	Continued From page 5 pain. Review of Resident #4's record revealed and order from the physician dated 09/22/16 for Mycolog cream (used to treat skin fungus) and TED hose apply after cream and before getting out of bed, off at bedtime. Review of Resident #4's Care Plan prepared by the Resident Care Coordinator (RCC) and signed by the Nurse Practitioner (NP) on 07/19/16 revealed: -Resident #4 was totally dependent on facility staff of all Activities of Daily Living, with the exception of eating, he needed supervision. -TED hose was not documented as a medically related personal care need for Resident #4. Review of Resident #4's October, and November 2016 electronic Medication Administration Records (eMARs) revealed TED hose was not documented on the eMARs. Review of Resident #4's record revealed no documentation of a Licensed Health Professional Support evaluation in the resident's record. Observation on 11/22/16 at 9:32 am of Resident #4 revealed: -The resident was sitting in a wheelchair in the common sitting room. -Resident #4 was not wearing TED hose. -Resident #4 was wearing white ribbed socks. Observation on 11/23/16 at 9:04 am of Resident #4 revealed: -The resident was lying in bed with his shoes on. -The resident was asleep. -The Personal Care Aide (PCA) woke the resident up and asked if she could pull this pants leg up.	{D 276}		

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{D 276}	Continued From page 6 -The resident went back to sleep. -Resident #4 was not wearing TED hose. -The resident had on white ribbed socks that were three inches above the resident's ankles. -There was impressions of the ribbed socks on both of the resident's legs but there were no visual signs of edema in the resident's legs and feet. Based on record review, observation, and attempt interview on 11/22/16, it was determined Resident #4 was not interviewable. Interview on 11/23/16 at 9:16 am the Personal Care Aide (PCA) on the first shift revealed: -Resident #4 had not worn TED hose for over one year. -She was unaware what happened to the resident's TED hose. -It was the facility's protocol the PCA on the third shift got the resident out of bed and put the resident's TED hose on. -The PCA identified the resident she was to put TED hose on because the Lead Medication Aide put the names on an assigned duty list. -The list was given out at the beginning of each shift. -Resident #4's name was not on the list to put TED hose on the resident. Review of the list given to the PCAs by the lead medication aide on 11/23/16 on the first, second, and third shift revealed Resident #4 as not on the list. Observation on 11/23/16 at 9:22 am of PCA searching Resident #4's room for TED hose revealed there was no TED hose found in the room.	{D 276}		

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{D 276}	Continued From page 7 Interview on 11/23/16 at 9:33 am with the Health and Wellness Director (HWD) revealed: -She started working at the facility /15/16, and did all resident paperwork. -She had not assessed or observed Resident #4 to see if he was wearing TED hose. -She had not reviewed Resident #4's record for orders missed. -It was the facility's protocol when orders were received for TED hose the Medication Aide receiving orders was to notify the Home Health nurse to measure the resident for TED hose, faxed the orders to pharmacy, input the orders in the eMAR system, and log the orders on the facility's new order tracking form. -After being notified the Home Health nurse came to the facility and measured the resident for TED hose. -The Home Health nurse was not notified and did not come to the facility to measure Resident #4 for TED hose. -If the Home Health nurse had measured Resident #4 she would have given the measurements to the MA, and the MA was supposed to fax the measurements to pharmacy. -However, there was no documentation to support this process had been done, so she believed Home Health had not measured Resident #4 for TED hose. -The RCC and the HWD reviewed the new order tracking forms to ensure staff followed the new process according to the facility's protocol. -She did not know why the order got filed in the resident's record and not entered into the eMARs. -If Resident #4 did not get the Mycolog cream ordered with the TED hose, then staff should have clarified the order for the TED hose with the resident's physician, and not filed the order away in the record.	{D 276}		

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{D 276}	Continued From page 8 Interview on 11/23/16 at 10:05 am with the Lead Medication Aide revealed: -It was the facility's protocol that when orders for TED hose were received the MA on duty measured the resident and faxed the order and measurements to pharmacy. -The MA was to enter the order on the eMAR. -The MA also entered the order onto the new order tracking form. -The new order tracking form was reviewed by the RCC and the HWD to ensure the MA followed the facility's protocol for receiving new orders. -The cream ordered with the TED hose was not in the building, so Resident #4's family may have refused to buy the cream. -If the Resident #4's family member did not buy the cream that was ordered with the TED hose, the MA should have contacted the physician to clarify if he still wanted the resident to wear the TED hose. Interview on 11/23/16 at 11:01 am with the Nurse Practitioner (NP) revealed: -The order Resident #4's TED hose was prior to her taking over as NP for the facility. -She had not been made aware the resident did not have TED hose. Interview on 11/23/16 at 11:17 am with the nurse at Resident #4's physician's office revealed: -The notes written by the physician on 09/22/16 showed Hospice sent a message to the physician stating the resident had 2+ edema and cellulitis. -The physician assessed the resident and wrote the resident had edema and stasis dermatitis. -There was no orders in their system that discontinued TED hose. -There was no notes of communication from the facility staff to inform the resident was not wearing TED hose.	{D 276}		

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{D 276}	Continued From page 9 -There was notes from the facility the resident's family refused to buy the Mycolog cream because it was expensive. -The Home Health nurse sent a note to the physician to inform Resident #4's family refused to buy the Mycolog cream. -The physician replaced the Mycolog cream with Nystatin cream (used to treat skin rash irritation). -No one informed the physician Resident #4 did not wear the TED hose. Interview on 11/23/16 at 11:44 am with Hospice nurse revealed: -The Licensed Practical Nurse (LPN) visited the resident on 9/21/16, and observed the resident had 2+ edema and possible cellulitis. -The Registered Nurse (RN) visited the resident on 09/26/16, and the resident had some swelling in his feet. -The RN also noted the physician wrote an order for Mycolog cream to on feet and place TED hose on before getting out of bed, take TED hose off at night. -They do not have an order to discontinue TED hose, so the resident should currently have TED hose. B. Review of Resident #5's current FL2 dated 10/25/16 revealed: -Diagnoses included dementia without behaviors, acute kidney failure, hypothyroidism and "gastroesophageal". -A physician's order for lisinopril 5 mg twice daily (a medication used to treat high blood pressure). -A Physician's order to obtain blood pressure weekly. Review of Resident #5's progress notes revealed: -An entry dated 10/27/16 with a documented blood pressure of 142/60.	{D 276}		

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{D 276}	Continued From page 10 -An entry dated 10/28/16 with a documented blood pressure of 138/60. -An entry dated 10/29/16 with a documented blood pressure of 130/66. -An entry dated 11/09/16 with a documented blood pressure of 138/76. Review of Resident #5's October, and November 2016 electronic Medication Administration Records (eMARs) revealed there were no entries to obtain blood pressures on the MARs. Based on record review, observation, and attempted interview on 11/22/16, it was determined Resident #5 was not interviewable. Interview with the MA on 11/22/16 at 2:28 pm revealed: -She was unaware there was a physician's order to obtain Resident #5's blood pressure weekly. -She did not enter the physician orders from Resident #5's FL2 to the eMAR. -If there was an order to obtain weekly blood pressures it should have been entered on the eMAR. Interview with Resident #5's Responsible Party (RP) on 11/23/16 at 10:35 am revealed: -Resident #5 did have high blood pressure and had experienced several transient ischemic attacks (mini-strokes) in the past. -Resident #5 took a medication to control her blood pressure, but could not recall the name of the medication. -The RP was unsure of how often Resident #5's blood pressure was monitored. Interview with the former Resident Care Coordinator (RCC) on 11/23/16 at 9:52 am revealed:	{D 276}		

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{D 276}	Continued From page 11 -She did enter the orders from the FL2 into the eMAR. -She did not recall Resident #5 had an order to obtain weekly blood pressures. -If there were specific orders to obtain the blood pressure it should have been entered onto the eMAR. -She must have over looked the weekly blood pressure order because had she noticed it she would have entered it onto the eMAR as it was considered an order. -There was no system in place to make sure what she entered onto the eMAR was accurate. Interview with the Health and Wellness Director (HWD) on 11/22/16 at 4:08 pm revealed: -She was unaware of the order to obtain Resident #5's blood pressure on a weekly basis. -"The weekly blood pressure should have been entered [onto the eMAR] and the former RCC just did not enter it." -They did monitor and document on new residents for at least three days. -Vitals signs are taken upon admission and may or may not be included on the three day monitoring documentation but in this case it was. Interview with the Administrator on 11/23/16 at 9:09 am revealed: -She was unaware there was on order on Resident #5's FL2 to obtain weekly blood pressures. -An order on the FL2 to obtain weekly blood pressures should have been entered onto the eMAR. Interview with Resident #5's Nurse Practitioner on 11/23/16 at 11:08 am revealed: -The first time she saw Resident #5 was last Thursday after Resident #5 was seen in the local	{D 276}		

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{D 276}	Continued From page 12 emergency department with a diagnosis of bronchitis. -She did not know about the weekly blood pressure order on the FL2, but did review Resident #5's record and there were no outstanding problems with her blood pressure. Based on record review, observations and interviews it was determined Resident #5 was not interviewable. C. Review of Resident #2's current FL2 dated 4/05/16 revealed: -Diagnoses included Alzheimer's Dementia, chronic dizziness, and hypothyroidism. -A physician's order for blood pressure (BP) checks daily. Review of Resident #2's record revealed: -A signed physician orders page dated 7/05/16 with an entry to "check BP every day. Fax results to [named physician] at the end of the month". The original order was dated 1/16/13. -A report from a physician's office visit dated 11/05/15 that documented a history of hypertension. -There was no documentation of BP results being faxed to Resident #2's physician. -There were no documentation of BP or vital signs in Resident #2's record. Review of Resident #2's October 2016 and November 2016 electronic Medication Administration Record (eMAR) revealed: -An entry to check BP every day and scheduled for 7:00 am. -BP checks were documented as obtained and initialed by staff from 10/01/16 to 10/31/16 and from 11/01/16 to 11/22/16, but no numerical BP values were entered.	{D 276}		

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{D 276}	Continued From page 13 Interview on 11/22/16 at 3:05 pm with Resident #2's family member revealed: -BP checks were to be obtained by the facility staff. -She had never been notified if there were "any issues" with Resident #2's BP. -Resident #2's physician came to the facility for visits. Interview on 11/22/16 at 3:55 pm with the Health and Wellness Director (HWD) revealed: -She had been the HWD since September 2016. -If the eMAR did not prompt the staff to record a BP result, then it was not recorded anywhere else. -Resident #2's eMAR only prompted the staff to document that the BP was obtained. -She was not aware Resident #2's BP results were not being documented in the record or eMAR. -The HWD and the Resident Care Coordinator (RCC) verified orders were entered correctly. The HWD, RCC or a Medication Aide (MA) entered orders into the eMAR, including entering BP prompts. -The facility went to an eMAR system in July 2016. The RCC or the MT entered task or treatment orders into the eMAR, and the pharmacy entered the medication orders into the system. -Resident #2 had changed physicians and no longer saw the named physician that the BP's were to be faxed to. -Resident #2's primary care physician's nurses came to the facility to visit her regularly and thought VS were being shared at those visits. Interview on 11/22/16 at 4:30 pm with a MA revealed: -She had been a MA at the facility for over one	{D 276}		

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{D 276}	Continued From page 14 year. -BP results were entered on the eMAR "if it was set up for us to record the BP, otherwise I just chart that the BP was done." -BP results were not recorded anywhere else in a resident's record. Interview on 11/23/16 at 9:10 am with another MA revealed: -She had worked at the facility for 9 years. -"If the eMAR does not ask me to record the BP result, there is not another way to enter it." -There were prompts to enter BP results for some residents, but not all. -She did not know the system was not set up to enter all BP results. -"This morning there was a prompt for Resident #2's BP to be entered, so I did". -"Before the eMARs we used paper MARs and wrote the BP results down. I do not know why we did not record them when we changed to eMAR." -She had not informed anyone that BP results could not be recorded for Resident #2. Review of Resident #2's eMAR on 11/23/16 at 9:10 am with the MA revealed only one BP result was documented in the record history, and it was 140/81 at 7:20 am on 11/23/16. The order was updated on 11/22/16 to enter the BP result. Interview on 11/23/16 at 9:52 am with the former RCC revealed: -She worked at the facility for 5 years and was currently a MA and Supervisor. -She was the RCC when the facility changed to eMARs, and entered treatment and task orders into the system along with other MAs. -BP results could only be entered into the eMAR if it was set up to prompt the MA to enter the result. -She was not aware Resident #2's BP results	{D 276}		

* * * Communication Result Report (Dec. 9. 2016 4:18PM) * * *

Fax Header)

Date/Time: Dec. 9. 2016 3:40PM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
1896	Memory TX	1412995392	P. 25	E-3) 3)	P. 1-25

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size

Targeted Selection® interview guide

Initiating Action

Taking prompt action to accomplish objectives; taking action to achieve goals beyond what is required; being proactive.

This competency relates directly to the Brookdale Cornerstone- *Take ownership and pride in everything we do.*

Key Actions
- Responds quickly
- Takes independent action
- Goes above and beyond

RATING

1. Describe a situation in which you identified a problem and took action to correct it.
2. Tell me about an idea that was implemented primarily because of your efforts.
3. Describe a time when you went beyond your job requirements to achieve an objective.

Situation/Task | Action | Result

Working at Family Practice - Things were not getting done (Realized Associates were not trained) Set up training

Doctor very happy - Paid a Bonus

FOLLOW-UP QUESTIONS TO BUILD COMPLETE STARS

For Situation/Task:	For Action:	For Result:
Describe a situation when . . . Why did you . . .? What were the circumstances surrounding . . .? What were you reacting to?	Exactly what did you do? Describe specifically how you did that. What did you do first? Second? Describe your specific role. Walk me through the steps you took.	What was the result? How did it work out? What happened as a result? What feedback have you gotten?

FOLLOW UP QUESTIONS FOR MOTIVATIONAL FIT

How satisfied/dissatisfied were you? How did you feel? What did you like/dislike?

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{D 276}	Continued From page 15 were not being recorded. Interview on 11/23/16 at 10:30 am with the Administrator revealed: -She expected physician orders to be followed. -The staff were trained to follow policies in managing orders and resident needs. -BP values should be documented and available for review. Interview on 11/23/16 at 11:15 am with the facility's contracted pharmacy revealed: -The current BP order in their system for Resident #2 was dated 7/07/16 to "check BP daily and fax results to [named physician] monthly". -There were no orders in the pharmacy's system regarding BP checks since the original order of January 2013. -There were no orders or notes in the pharmacy's system to no longer send BP results to Resident #2's physician. -When the facility changed to eMARs the pharmacy entered medication orders, and the facility entered task or treatment orders into the system. Interview on 11/23/16 at 11:30 am with Resident #2's Hospice physician's office staff revealed: -The Hospice nurse checked a resident's BP each visit as part of their assessment. -Daily BP checks were to be performed by the facility if that was an order from the Resident's primary care physician. -Resident #2's care was to be ordered by her primary care physician. "We correlate with him." Attempted interview with Resident #2's primary care physician or nurse on 11/23/16 at 11:55 am was unsuccessful.	{D 276}		

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{D 276}	Continued From page 16 Based on observations, record review and interviews with staff, it was determined Resident #2 was not interviewable.	{D 276}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to clarify unclear or conflicting medication orders for 4 of 5 sampled residents (#1, #2, #4 and #5) regarding medication orders for blood thinners (Resident #1), diabetes (Resident #2), pain (Resident #4), urinary tract infection, and mineral supplements (Resident #5). The findings are: A. Review of Resident #1's current FL2 dated 3/23/16 revealed: -Diagnoses included hypotension, atrial fibrillation, chronic renal disease, coronary artery	D 344		

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D 344	Continued From page 17 disease, peptic ulcer and esophagitis. -A physician's order for Eliquis 2.5 mg every 12 hours (an anti-coagulant used to lower the risk of stroke with atrial fibrillation). Review of Resident #1's record revealed: -Subsequent physician's orders signed and dated 6/29/16 for Eliquis 2.5mg every 12 hours. -A signed prescription form from Resident #1's cardiologist dated 9/23/16 with "Veteran's Administration (VA) changed patient from Eliquis to Warfarin. Please refer to [named physician's] office note for orders". -An office visit note dated 9/23/16 from Resident #3's cardiologist with a handwritten arrow pointing to documentation that the "VA Hospital...have requested that the Eliquis be changed to Coumadin. I have no problem with that provided his PT and INR are monitored by the VA". (Prothrombin Time (PT) and International normalized ratio (INR) are lab tests to monitor how thin the blood is when on Coumadin). -There were no documentation or orders for Coumadin (Warfarin) clarification in the record. -There was a Physician's Assistant (PA) visit dated 9/23/16 with no mention of blood thinners in the documentation. Review of Resident #1's October 2016 electronic Medication Administration Record (eMAR) revealed: -An entry for Eliquis 2.5 mg twice a day and documented as administered at 9:00 am and 9:00 pm from 10/01/16 to 10/31/16 except for the 9:00 pm dose on 10/23/16. -The 10/23/16 9:00 pm entry was not documented as administered, but had an exception note documented "waiting on delivery". Review of Resident #1's November 2016 eMAR	D 344		

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D 344	Continued From page 18 revealed: -An entry for Eliquis 2.5 mg twice a day and scheduled for administration at 9am and 9 pm. -Eliquis 2.5 mg was documented as administered twice a day from 11/01 to 11/20/16. -The morning dose of Eliquis was documented as administered at 9:00 am from 11/01 to 11/03/16, and at 8:00 am from 11/04/16-11/21/16. -The evening dose of Eliquis was documented as administered at 9:00 pm from 11/01 to 11/21/16. -The 11/22/16 9:00 am entry was not documented as administered, but had an exception note documented "waiting on delivery". Observation of medications on hand for Resident #1 on 11/22/16 at 2:30 pm revealed no Eliquis 2.5 mg available to be administered. Interview on 11/22/16 at 2:30 pm with a Medication Aide revealed: -Resident #1's Eliquis was obtained from the Veteran's Administration hospital by the family. -The family were contacted, but the medication had not been sent to the facility yet. -The local pharmacy was contacted and the Eliquis was to be "sent out on the next medication delivery, which should arrive this afternoon". -We had no actual discontinue order, so the Eliquis was continued and not changed to Coumadin. -She had not contacted the physician to clarify the Eliquis order. Telephone interview on 11/22/16 at 2:40 pm with the facility's contracted pharmacy representative revealed: -There was an active order for Resident #1 in their system for Eliquis 2.5 mg twice a day. It was last filled on 9/11/16, and was scheduled to be filled 11/22/16.	D 344		

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D 344	Continued From page 19 -There was no order or notes in their system regarding Coumadin or Warfarin. Interview on 11/22/16 at 3:00 pm with the Health and Wellness Director (HWD) revealed: -She had worked at the facility since 9/20/16. -She was not aware of the notes about changing Eliquis to Coumadin. -The "process to clarify orders would be that [Resident #] would have to see his physician for the order change from Eliquis to Coumadin". Telephone interview on 11/23/16 at 9:35 am with the facility's contracted pharmacy's Pharmacist revealed: -He was at the facility on 11/20/16 for the latest pharmacy reviews. -He remembered seeing the note in Resident #1's record about changing from Eliquis to Coumadin per the VA hospital's request, but did not find an order to change to Coumadin. -His typed report of the pharmacy reviews was not completed yet, so the facility did not have his recommendations to follow-up on the Eliquis vs. Coumadin. -The active order in the pharmacy system was for Eliquis 2.5 mg twice a day. -"The resident gets some medications from the VA hospital, so the orders get complicated sometimes." Interview on 11/23/16 at 9:52 am with the former RCC revealed: -She had worked at the facility for 5 years, and was currently a MA/Supervisor. -She had been the RCC for 1 year. -If clarification of orders were needed, any MA was supposed to fax the resident's physician for those orders. -In regards to the Eliquis to Coumadin change,	D 344		

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D 344	Continued From page 20 "the MA on duty should have followed up or passed it on to the RCC or HWD to follow-up" to clarify that order. -She "was not aware of that order needing to be clarified". Interview on 11/23/16 at 10:30 am with the Administrator revealed: -She expected orders to be clarified as needed. -The staff were trained to follow policies in managing orders and residents' needs. Interview on 11/23/16 at 11:00 am with Resident #1's Nurse Practitioner revealed: -She was not aware of the Eliquis to Coumadin note. -The facility had not contacted her for orders to change to Coumadin. -If the facility had contacted her, she would have "referred them to check with the VA physician for orders" including dose, frequency and lab monitoring. Attempted telephone interview on 11/22/16 with Resident' #1's family member was unsuccessful. Based on observations, record reviews and interviews with staff, it was determined Resident #1 was not interviewable about his medications and treatment. B. Review of Resident #2's current FL2 dated 4/05/16 revealed: -Diagnoses included Alzheimer's Dementia, chronic dizziness, and hypothyroidism. -A physician's order for Glucotrol 5 mg daily (a medication used to treat type 2 diabetes). -A physician's order for "finger stick blood sugar (FSBS) checked every morning, fax results at the end of every month".	D 344		

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D 344	Continued From page 21 -A physician's order "if FSBS is <60, hold insulin and/or diabetic medications. If FSBS is >350, call physician unless otherwise directed. Recheck FSBS prn (as necessary) if signs and symptoms of hypo/hyperglycemia." Review of Resident #2's record revealed: -A report from a physician's office visit dated 11/05/15 documented a history of hypertension and diabetes. -There was no physician's order for insulin in Resident #2's record. Review of Resident #2's October 2016 and November 2016 electronic Medication Administration Records (eMARs) revealed: -An entry for FSBS every morning at 7:00 am with parameters for instructions to call physician or hold diabetic medications. -Documented FSBS for October ranged from 67 to 109. -Documented FSBS for November ranged from 82 to 125. -There was no entry for Glucotrol 5 mg daily on the eMARs. Observation of medications on hand for Resident #2 on 11/22/16 at 2:30 pm revealed no Glucotrol available to be administered. Telephone interview on 11/22/16 at 2:40 pm with the facility's contracted pharmacy representative revealed: -A physician's order to discontinue Glucotrol for Resident #2 on 3/17/16 and was not restarted. -There was "no copy of Resident #2's current FL2 dated 4/05/16 in their system, so they did not have an order for Glucotrol for that date". Interview on 11/22/16 at 3:00 pm with the Health	D 344		

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D 344	Continued From page 22 and Wellness Director (HWD) revealed: -She had worked at the facility since 9/20/16. -She was not aware who wrote Resident #2's FL2 for the physician to sign, as "she was not working" at the facility at that time. -The HWD and the Resident Care Coordinator (RCC) verified orders were entered correctly in the eMAR system by the pharmacy. Telephone interview on 11/22/16 at 3:05 pm with Resident #2's family member revealed: -She "thought (Resident #2) was taken off the diabetes medication over the summer because she had lost weight, according to what a staff member told her". -"The blood sugars got really low, so Hospice was contacted, but they were never told (Resident #2) was on a diabetes medication. The Hospice physician discontinued the diabetes medication." Interview on 11/23/16 at 9:52 am with the former RCC revealed: -She had worked at the facility for 5 years. -She had been the RCC for 1 year. -If clarification of orders were needed, any MA was to fax the MD for those orders. -She "was not sure who filled out Resident #2's current FL2" dated 4/05/16 for the physician to sign, but "it might have been me". -When she filled out a resident's FL2, she used the most recent MAR as the reference for medications. -She was not aware why the Glucotrol was on Resident #2's FL2, unless she had filled it out before the Glucotrol was discontinued. Interview on 11/23/16 at 10:30 am with the Administrator revealed: -She expected orders to be clarified as needed. -The staff were trained to follow policies in	D 344		

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D 344	Continued From page 23 managing orders and residents' needs. Telephone interview on 11/23/16 at 11:30 am with Resident #2's Hospice physician's office nurse revealed: -Hospice was consulted for Resident #2 on 11/20/15. -Glucotrol was not "active on the medication list" in their system. -A resident's primary care physician still managed "those types of medications. We collaborate care with the primary physician." Telephone interview on 11/23/16 at 11:55 am with Resident #2's primary care physician or nurse was not available. C. Review of Resident #4's current FL2 dated 07/19/16 revealed: -Diagnoses included dementia, hypertension, chronic kidney disease stage 2, and low back pain. -Medication orders by the physician included Tramadol 50mg every 8 hours as needed (PRN) for pain. Review of Resident #4's record revealed: -An order signed by the Nurse Practitioner (NP) dated 05/03/16 for Tramadol 50mg three times daily routinely. -Documentation the physician noted the resident was having back pain. Review of Resident #4's record revealed there was no order to discontinue the Tramadol 50mg three times daily. Observation on 11/22/16 at 12:37 pm of Resident #4's medications on hand at the facility revealed: -Tramadol 50mg was on hand at the facility.	D 344		

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D 344	Continued From page 24 -The administration instructions was covered by a sticker that stated "instructions have changed." -The medication was dispensed on 05/03/16 for 90 tablets. -There were 37 tablets remaining. Review on 11/23/16 of the facility's narcotic sheet revealed the last time staff administered a Tramadol was 8/17/16. Review of Resident #4's September and October 2016 electronic Medication Administration Records (eMARs) revealed: -Tramadol 50mg three times daily was not documented on the eMARs. Interview on 11/22/16 at 4:16 pm with the dispensary pharmacist revealed: -They received an order to for Tramadol 50mg three times daily on 05/03/16. -The pharmacy filled the medication for 90 tablets. -Tramadol was a narcotic and would not automatically be refilled. -To refill the medication the facility had to call and request a refill. -Resident #4 also had orders for Tramadol 50mg every 8 hours as needed for pain. -If the resident no longer needed Tramadol 50mg three times daily, then facility staff should clarify the order with the physician. Interview on 11/22/16 at 4:10 pm with the first shift Medication Aide (MA) revealed: -Resident #4 had current orders for Tramadol 50mg every 8 hours as needed for pain. -She was unaware the resident had an order for Tramadol 50mg three times daily. -She looked at the resident's eMARs and it appeared in May 2016, the resident was ordered	D 344		

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D 344	Continued From page 25 Tramadol 50mg three times daily. -The resident received the medication until May 13th, and then went to the hosptial. -When Resident #4 left the hospital his orders included Tramadol 50mg every 8 hours as needed for pain. -There was no order to discontinue Tramadol 50mg three times daily. -She did not think to clarify the order with the physician. -Resident #4's mental cognition was not good because he had dementia, but Resident #4 was able to express when he had pain. -Resident #4 had not complained about pain within the last several months. -It had been a long time since Resident #4 was given Tramadol for pain. Interview on 11/23/16 at 9:33 am with the Health and Wellness Director (HWD) revealed: -She started working at the facility on 09/15/16. -She had not been through resident records. -She thought staff did not administer the Tramadol 50mg three times daily because the resident was not in pain. -However, staff should not have stopped administering the medication without a discontinuation order. -If staff was unsure to give Tramadol routine or PRN they should have clarified the order with the physician. Interview on 11/23/16 at 11:01 am with the Nurse Practitioner (NP) revealed: -The order for Tramadol was prior to her taking over at the facility in late September 2016. -She was unaware Resident #4 had an order for Tramadol 50mg three times daily and Tramadol 50mg every 8 hours as needed (PRN). -She did not order the Tramadol 50mg three	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041033	A. BUILDING: _____ B. WING _____	R 11/23/2016

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D 344	Continued From page 26 times daily, however if facility staff felt the resident did not need the medications they should have clarified the order with the resident's physician. -She talked with facility staff today (November 23, 2016), and it did not appear the resident was having pain, so she wrote a clarification order today to discontinue Tramadol 50mg three times daily, and administer Tramadol 50mg every 8 hours PRN for pain. D. Review of Resident #5's current FL2 dated 10/25/16 revealed: -The diagnoses included dementia without behaviors. -A physician's order for AZO 250mg 2 tablets twice daily (a medication used to treat discomfort associated with urinary track infections), calcium carbonate 500 units/5ml once daily (a liquid calcium supplement used in place of a tablet to ease administration) and cranberry tablets twice daily (a medication used to prevent urinary tract infections). Review of the Patient Medication Discharge Sheet dated 10/25/16 revealed: -The form was a computer generated form from Resident #5's previous facility. -The form was not signed by a licensed prescribing practitioner. -The medication list on the form included orders for cranberry 475 mg twice daily, calcium carbonate with vitamin D was 500mg-400mg/5 ml liquid every morning and AZO cranberry 2 tablets twice daily. Observation of medications on hand for Resident #5 on 11/22/16 at 2:28 pm revealed: -A bingo card of oyster shell calcium 500mg tablets available for administration.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 344	Continued From page 27 -There were 6 of the oyster shell calcium tablets remaining. -The medication was filled on 10/27/16. -There was no AZO cranberry or cranberry tablets on the medication cart for Resident #5 Review of Resident #5's October 2016 electronic Medication Administration Record (eMAR) revealed: -A computerized entry for oyster shell calcium 500mg 1 tablet once daily and documented as administered once daily at 9:00 am on 10/29, 10/30 and 10/31/16. -A computerized entry for AZO-cranberry 250-30mg 2 tablets twice daily and documented as administered twice daily at 9:00 am on 10/29, 10/30 and 10/31/16 and 9:00 pm 10/28, 10/29, 10/30 and 10/31/16. -A computerized entry for cranberry tablets 475 mg 1 tablet twice daily and documented as held at 9:00 am on 10/28/16 and 9:00 pm 10/27/16. Review of Resident #5's November 2016 eMAR revealed: -A computerized entry for oyster shell calcium 500mg 1 tablet once daily and documented as administered once daily at 9:00 a.m. on 11/01 though 11/22/16. -A computerized entry for AZO-cranberry 250-30mg 2 tablets twice daily and documented as administered twice daily at 9:00 am and 9:00 pm on 11/01 through 11/21/16. -No entry for cranberry tablets. Interview with a Medication Aide (MA) on 11/22/16 at 3:50 pm revealed: -MAs were able to enter new orders into the eMAR. -She would check the new orders that were entered into the eMAR against the written	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 344	Continued From page 28 physician's order. -For a new resident she would check the eMAR's for accuracy by comparing them to the orders on the FL2. -If there was a difference between what was entered on the eMAR verses what was on the FL2 she would clarify the order with the prescribing physician. -She thought the MAs had two days to clarify orders. -She was unaware there were discrepancies with Resident #5's orders and what was entered on the eMAR. Interview with a representative from the contracted pharmacy on 11/22/16 at 1:57 pm revealed: -The physician's order for the calcium, the AZO and the cranberry were all obtained from the FL2 dated 10/25/16. -There was also a Patient Medication Discharge Sheet dated 10/25/16 that the facility faxed to them with the FL2, but it did not have a signature from a prescribing practitioner. -The Patient Medication Discharge Sheet was generated by Resident #5's previous facility. -The pharmacy utilized this to clarify the dose of the cranberry order as the Patient Medication Discharge Sheet specified cranberry 475 mg twice daily. -They were unable to supply cranberry 475 mg. -The Patient Medication Discharge Sheet did include the calcium carbonate with vitamin D was 500mg-400mg/5 ml liquid every morning, which they were also unable to provide. -On 10/27/16 the pharmacy filled 30 tablets of oyster shell calcium 500mg with instructions to take one tablet daily and 30 tablets of AZO-cranberry 250-30mg with instructions to take two tablets twice daily.	D 344		

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D 344	Continued From page 29 Interview with the former Resident Care Coordinator (RCC) on 11/23/16 at 9:52 am revealed: -She did enter the orders from the FL2 into the eMAR. -She did not recall a Patient Medication Discharge Sheet or faxing it to the pharmacy. -She did not recall Resident #5 had an ordered for liquid calcium. -She was aware Resident #5 had orders for cranberry and AZO. -She was able to identify"cranberry twice daily" was not a complete order but did not call the physician for clarification. -If she had noticed it should would have either called or faxed Resident #5's physician for clarification. -She would have also requested the substitution orders for calcium tablets in lieu of liquid and the AZO cranberry combination pill in lieu of the separate tablets, but did not know the pharmacy could not supply the medications as ordered. Interview with the Health and Wellness Director (HWD) on 11/22/16 at 4:08 pm revealed: -If there was a discrepancy between the FL2, discharge summary or what the pharmacy could supply there should have been a clarification written on the FL2 addendum. -The former RCC should have faxed the FL2 addendum with the discrepancies to the physician. -She did not know of the Patient Medication Discharge Sheet. -The pharmacy was to supply the medications based on what was on the FL2 and the former RCC was to check to make sure that the medications came to the facility and ensured they were accurate when compared to the orders and	D 344		

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D 344	Continued From page 30 the eMAR. -She was unaware the calcium was ordered in a liquid form and the pharmacy substituted the tablets. -She was unaware the pharmacy substituted the AZO cranberry tablets for the individual orders for cranberry tablets and AZO tablets. -She would expect the pharmacy to call the facility staff and notify them of the inability to obtain the medications as ordered and did not know if this occurred. -She did not know why these medications were being administered without physician orders. Interview with the Administrator on 11/23/16 at 9:09 am revealed: -She had only been the Administrator for this facility for two months. -She was not aware the FL2 and the Patient Medication Discharge Sheet had orders that were inconsistent with those being administered on the eMAR. -She was aware the former RCC was not trained properly and should have implemented the physician orders from the FL2 and/or obtained clarification. -When she identified the former RCC as not fully capable of handling the position of RCC she moved her back to the position of lead medication aide and hired a new RCC who was also a Licensed Practical Nurse (LPN). Interview with Resident #5's Nurse Practitioner on 11/23/16 at 11:08 am revealed: -The first time she saw Resident #5 was last Thursday after Resident #5 was seen in the local emergency department with a diagnosis of bronchitis. -The facility staff had not contacted her about the calcium until this morning.	D 344		

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D 344	Continued From page 31 -She did give the facility staff permission to use the oyster shell calcium tablets in lieu of the liquid. -The facility staff had not informed her of the substitution of AZO-cranberry for separate AZO 250mg tablets and cranberry tablets. Based on record review, observations and interviews it was determined Resident #5 was not interviewable.	D 344		
{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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by the licensed prescribing practitioner for 1 of 4 residents (Resident #5) observed during the medication pass, including errors with AZO and liquid calcium. The findings are:	{D 358}		

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{D 358}	Continued From page 32 A. Review of Resident #5's current FL2 dated 10/25/16 revealed: -The diagnoses included dementia without behaviors. -A physician's order for AZO 250mg 2 tablets twice daily (a medication used to treat discomfort associated with urinary track infections), calcium carbonate 500 units/5ml once daily (a liquid calcium supplement used in place of a tablet to ease administration) and cranberry tablets twice daily (a medication used to prevent urinary tract infections). Review of Resident #5's record revealed she had been seen in the emergency department on 11/11/16 and was diagnosed with bronchitis. Review of Resident #5's October 2016 electronic Medication Administration Record (eMAR) revealed: -A computerized entry for oyster shell calcium 500mg 1 tablet once daily and documented as administered once daily at 9:00 am on 10/29, 10/30 and 10/31/16. -A computerized entry for AZO-cranberry 250-30mg 2 tablets twice daily and documented as administered twice daily at 9:00 am on 10/29, 10/30 and 10/31/16 and 9:00 pm 10/28, 10/29, 10/30 and 10/31/16. -A computerized entry for cranberry tablets 475 mg 1 tablet twice daily and documented as held at 9:00 am on 10/28/16 and 9:00 pm 10/27/16. Review of Resident #5's November 2016 eMAR revealed: -A computerized entry for oyster shell calcium 500mg 1 tablet once daily and documented as administered once daily at 9:00 a.m. on 11/01 though 11/22/16. -A computerized entry for AZO-cranberry	{D 358}		

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{D 358}	Continued From page 33 250-30mg 2 tablets twice daily and documented as administered twice daily at 9:00 am and 9:00 pm on 11/01 through 11/21/16. -No entry for cranberry tablets. Observation during the 8:00 am medication pass on 11/22/16 revealed: -At 9:57 am the Medication Aide (MA) pulled Resident #5's card of oyster shell calcium 500mg tablets from the medication cart. -She put one tablet in the medication cup along with 11 other tablets. -Resident #5 was administered the medications with a cup of water and swallowed them without difficulty at 10:10 am. -The MA documented administration immediately after the medication was administered. Observation of the card of oyster shell calcium revealed: -There were 6 of the oyster shell calcium 500mg tablets. -The medication was filled on 10/27/16. -There was no AZO cranberry or cranberry tablets on the medication cart for Resident #5. Interview with the MA on 11/22/16 at 10:17 am revealed: -She was unable to administer the AZO because it was not on the medication cart. -She ordered the AZO through the computer and thought it could be delivered and administered within the next hour. -The last time the AZO had been ordered per the computer was 10/27/17. -The(Staff?) usually ordered the medications when they got down to about 5 days left and did not know why it had not been ordered. A second interview with the MA on 11/22/16 at	{D 358}		

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{D 358}	Continued From page 34 2:28 pm revealed: -They still did not have the AZO available for Resident #5 and it would be arriving within a few hours. -She was unaware calcium was ordered as a liquid rather than the oyster shell calcium tablet she administered that morning. Interview with a representative from the contracted pharmacy on 11/22/16 at 1:57 pm revealed: -The physician's order for the calcium, the AZO and the cranberry were all obtained from the FL2 dated 10/25/16. -On 10/27/16 the pharmacy filled 30 tablets of oyster shell calcium 500mg with instructions to take one tablet daily and 30 tablets of AZO-cranberry 250-30mg with instructions to take two tablets twice daily. -They had not refilled the AZO-cranberry 250mg. -They refilled medications based on the requests from the facility whether via fax or phone. -They had not received any refill requests from the facility for Resident #5's AZO-cranberry 250mg. -The pharmacy was unable to obtain the liquid calcium as ordered on the FL2 and this was communicated to the facility. -The pharmacist did send a notification fax to the physician, but ultimately expected the facility to obtain an order for the substitution for both the AZO-cranberry and the oyster shell calcium tablets. A second interview with a representative from the contracted pharmacy on 11/23/16 at 10:24 am revealed: -They never supplied the facility with cranberry tablets, but they could supply them in 405 mg, 450 mg and 500mg tablets.	{D 358}		

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{D 358}	Continued From page 35 -They never dispensed liquid calcium as they were unable to obtain the liquid in the concentration the physician ordered. -The pharmacist used a "therapeutic interchange" and this was used when the pharmacy did not have the exact medication, but could substitute another medication utilized for the same indication. -The therapeutic interchange was agreed upon on a corporate level between the facility and the pharmacy. -The facility was responsible for obtaining the clarification from the physician. Interview with Resident #5's Responsible Party (RP) on 11/23/16 at 10:35 am revealed: -Resident #5 began to present with swallowing problems approximately 5 years ago. -Resident #5 did have difficulty eating and had been hospitalized twice for electrolyte imbalance secondary to insufficient intake, and she had pneumonia in the past. -The facility sent Resident #5 to the emergency room for severe bronchitis in a timely manner. -She had never noticed Resident #5 having any difficulty swallowing her medications. -She thought Resident #5 was taking speech therapy. -The chest x-ray showed severe bronchitis without pneumonia. -The physician at the emergency department did not think the bronchitis was related to aspiration, but was related to a cold. Interview with the former Resident Care Coordinator (RCC) on 11/23/16 at 9:52 am revealed: -She did enter the orders from the FL2 into the eMAR. -She did not recall Resident #5 had an ordered	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 358}	Continued From page 36 for liquid calcium. -She was aware Resident #5 had orders for cranberry and AZO. -She was able to identify"cranberry twice daily" was not a complete order but did not call the physician for clarification. -If she had noticed it should would have either called or faxed Resident #5's physician for clarification. -She would have also requested the substitution orders for calcium tablets in lieu of liquid and the AZO cranberry combination tablet in lieu of the separate tablet,s but did not know the pharmacy could not supply the medications as ordered. -There was no system in place to make sure what she entered into the eMAR was accurate. -The facility did have a new order tracking form, but MAs did not use this tool for admissions because they only used it for new orders. Interview with the Health and Wellness Director (HWD) on 11/22/16 at 4:08 pm revealed: -If there was a discrepancy between the FL2, discharge summary or what the pharmacy could supply there should have been a clarification written on the FL2 addendum. -The former RCC should have faxed the FL2 addendum with the discrepancies to the physician. -The pharmacy was to supply the medications based on what was on the FL2 and the former RCC was to check to make sure that the medications came to the facility and ensured they were accurate when compared to the orders and the eMAR. -She also would check the eMARs and medications on hand to ensure accuracy, but had not had a chance to check Resident #5's yet. -She was unaware the calcium was ordered in a liquid form and the pharmacy substituted the	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 358}	Continued From page 37 tablets. -She was unaware the pharmacy substituted the AZO cranberry tablets for the individual orders for cranberry tablets and AZO tablets. -She would expect the pharmacy to call the facility staff and notify them of the inability to obtain the medications as ordered and did not know if this occurred. -She did not know why these medications were being administered without physician orders. Interview with the Administrator on 11/23/16 at 9:09 am revealed: -She had only been the Administrator for this facility for two months. -She was not aware of the calcium tablets being administered in lieu of the liquid and was unaware the AZO cranberry was being administered in one tablet rather than two separate tablets as indicated on the FL2. -She was aware the former RCC was not trained properly and should have implemented the physician orders fro the FL2 and/or obtained clarification. -When she identified the former RCC as not fully capable of handling the position of RCC she moved her back to the position of lead medication aide and hired a new RCC who was also a Licensed Practical Nurse (LPN). Interview with Resident #5's Nurse Practitioner on 11/23/16 at 11:08 am revealed: -The first time she saw Resident #5 was last Thursday after Resident #5 was seen in the local emergency department with a diagnosis of bronchitis. -The facility staff had not contacted her about the calcium until this morning. -She did give the facility staff permission to use the oyster shell calcium tablets in lieu of the	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 358}	Continued From page 38 liquid. -The facility staff had not informed her of the substitution of AZO-cranberry for separate AZO 250mg tablets and cranberry tablets. -She was not aware that Resident #5 had a history of dysphagia. Based on record review, observations and interviews it was determined Resident #5 was not interviewable.	{D 358}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL041033 Y1	A. Building B. Wing Y2	11/23/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HIGH POINT NORTH	1564 SKEET CLUB ROAD HIGH POINT, NC 27265

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0131 Reg. # 10A NCAC 13F .0406(a) LSC	Correction Completed 09/23/2016	ID Prefix D0167 Reg. # 10A NCAC 13F .0507 LSC	Correction Completed 10/13/2016	ID Prefix D0468 Reg. # 10A NCAC 13F .1309 LSC	Correction Completed 10/13/2016
ID Prefix D912 Reg. # G.S. 131D-21(2) LSC	Correction Completed 10/13/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	12/09/16 DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/17/2016	☐ YES ☐ NO

The following is a summary of the Plan of Correction for Brookdale High Point North-MC. This Plan of Correction is in regards to the Corrective Action Report dated December 9, 2016. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is 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. All of the below information will be addressed by the 4th of January, 2017.

10A NCAC 13F .0902 Health Care
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of resident's records

- The specific resident in question had a Speech Therapy request made, with a visit completed on 11/29/16, to determine the need for any outstanding healthcare follow up.
- An audit of the remainder of the current resident charts was completed on 11/30/16 to determine the need for any outstanding healthcare follow up.
- Any follow up/clarification discovered was handled at that time by the Health and Wellness Director/Resident Care Coordinator/Designee with appropriate follow through completed.
- A New Order Tracking Form is now being utilized by associates for any new/changed orders to include any therapy 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.
- 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 the A New Order Track Form for any follow-up and order processing per policy, to include therapy referrals by the Health and Wellness Director/Resident Care Coordinator.

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 such as placement of TED Hose, B/P readings.
- 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 TED Hose or B/P readings by the Health and Wellness Director/Resident Care Coordinator.

10A NCAC 13F .1002 Medication Orders

(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:

(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;

(2) if orders are not clear or complete; or

(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.

The facility shall ensure that this verification or clarification is documented in the resident's record.

- Orders for medications and treatments will be transcribed to the electronic MAR as well as being filed in the resident's healthcare record upon receipt per policy.
- A "New Order Tracking Form" will be utilized by associates for any new/changed orders.
- If there are any unclear, or conflicting orders, the physician will be contacted for clarification at that time by associates, with follow up review completed by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee.
- A "New Order Tracking Form" will be reviewed by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee daily for one month, when present in the community, for completion of orders and appropriate follow through.
- Thereafter A "New Order Tracking Form" will be reviewed randomly, but at least on a weekly basis by the Executive Director/Health and Wellness Director/Resident Care Coordinator/Designee.
- Appropriate associates will be reeducated regarding the use of A New Order Track Form and order processing per policy, to include the need for any clarification of orders if unclear or if there are any conflicting orders.

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 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.
- Associates were retrained regarding the 7 Rights of Medication Administration per policy, to include comparison of the medication order with the medication on hand to administer, by the Health and Wellness Director/Resident Care Coordinator.
- Medications 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, assuring that medications delivered match the medication order per policy.
- There after a "New Order Tracking" form will be utilized as indicated, to include delivery of appropriate medications, by the Executive Director/Health and Wellness Director/Resident at least on a weekly basis.