STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041030	A. BUILDING: _____ B. WING _____ AUG 24 2017	R 07/07/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on July 6-7, 2017.	{D 000}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Non-compliance continues Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a prescribing licensed practitioner for 2 of 5 sampled residents (Resident #5 and #1) with orders for an anti-depressant (#5) and an anticoagulant (#1) The findings are: A. Review of Resident #5's current FL dated 4/19/17 revealed: -Diagnoses included hypertension, adult onset diabetes mellitus, hypothyroidism, chronic pain, insomnia, anemia, hyperlipidemia, and incontinence. -A physician's order for Cymbalta 30 mg daily. Review of Resident #5's May, June and July 2017	{D 358}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ryan Bostaut, TITLE: Executive Director, (X6) DATE: 08-18-17

Reviewed and accepted. AJS 8/24/17

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 3 consecutive days 6/22/17 Thursday 2 5 mg Coumadin, 6/23/17 Friday 5 mg Coumadin and 6/24/17 Saturday 5mg Coumadin. Review of Resident #1's Home Health progress notes revealed: -The home health notes included laboratory blood work INR (International Normalized Ratio) (laboratory result used with Coumadin to evaluate the thinnest of the blood). -An INR was documented on 6/13/17 with a result of 1.6 (normal INR 2.0-3.0) -A second INR was documented on 6/28/17 with a result of 1.8. Telephone interview on 7/7/17 at 2.30 pm with the Home Health Nurse revealed. -She was responsible for obtaining the INR from Resident #1. -She had taken the lab draw via fingerstick and immediately obtained the results on 6/13/17 and 6/28/17 -She sent the results to the physician for review and obtained new orders for the Coumadin administration. -She was not aware Resident #1 missed 3 days of Coumadin on 6/22/17, 6/23/17, and 6/24/17. -Resident #1's current Coumadin dose order as of 6/28/17 was Coumadin 5 mg every day. Interview on 7/7/17 at 4:00 pm with the second shift Medication Aide (MA) revealed: -She had worked in the facility for about 6 months. -She always compared the medications to the eMAR prior to administering medications to the residents. -She could not recall missing any days in the month of June 2017 administering Resident #1's Coumadin	{D 358}		

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{D 358}	Continued From page 4 -"There were many changes in the last few weeks to Resident #1's Coumadin dose, maybe someone was unsure how much to give." -She was unsure who was responsible for checking holes in the eMAR monthly, or if they were checked at all. Interview on 7/7/17 at 3:05 pm and on 7/8/17 at 9:00 am with the Resident Care Coordinator (RCC) revealed. -The MAs were responsible for putting orders in the eMAR system and verifying they were correct. -She was not aware Resident #1 had 3 consecutive missed doses of Coumadin on 6/22/17, 6/23/17, and on 6/24/17. -She thought the MAs were administering the medications as ordered by the physician. -"Maybe it was a new MA and they were unsure of the dose of Coumadin." -"I am not sure what happened." -She was responsible for overseeing the clinical staff and reviewing resident's records and new orders. -The facility had no current system in place for tracking Coumadin or INR levels. Telephone interview on 7/8/17 at 11:30 am with Resident #1's physician revealed: -The physician was unaware Resident #1 had 3 consecutive missed doses of Coumadin on 6/22/17, 6/23/17 and on 6/24/17. -He relied on the facility staff to administer the medications to Resident #1 as ordered. -He was aware Resident #1's INR result was 1.6 on 6/13/17 and on 6/28/17 the INR result was 1.8 -He assumed since the INR had increased the facility staff had administered the Coumadin as ordered. -The three missing doses of Coumadin were not detrimental to Resident #1 because the INR had	{D 358}		

The following is a summary of the Plan of Correction for Brookdale High Point. This Plan of Correction is in regards to the Corrective Action Report dates July 7, 2017. This Plan of Correction is not to be constructed as an admission of or agreement with the findings and conclusions in the State of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation, nor have we identified mitigating factors.

10A NCAC 13F. 1004 Medication Administration

An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

- The ED will in-service medication aids & LPN's on the 7 rights of medication administration per policy, to be completed by September 1, 2017. The ED/HWD or Designee will follow up on New Order Tracking forms to ensure accuracy and proper transcription of physician orders twice weekly for 6 weeks while in the community. ED will verify that lab book is in place to keep a record of labs & Coumadin INR/Protime Flow Sheets. ED/ HWD or Designee will review lab book weekly for 6 weeks for appropriate follow up. Plan of correction to be completed by September 30, 2017.

Ryan Board, ED
08.18.17