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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on January 16, 22, and 23, 2018.	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 observation, interviews, and record reviews, the facility failed to assure physician notification of an INR lab test not attained as ordered and INR lab results for 1 of 1 resident (Resident #3) currently taking Coumadin. The findings are: Review of Resident #3's current FL2 dated 7/20/17 revealed: -Diagnoses included atrial fibrillation, cardiomyopathy, cardiac dysrhythmias, and hypotension. -There was no standing physician's lab order to obtain a INR for anticoagulation therapy. INR stands for (international normalized ratio and is a measure of the effectiveness of Coumadin to prevent blood clots. Depending on the condition being treated, a desired INR range would be 2.0 to 3.0.) Review of Resident #3's record revealed: -A subsequent physician order dated 12/18/17 to hold Coumadin tonight and then resume Coumadin 4mg every night except Saturday,	D 273		

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administer 2mg on Saturday. Repeat INR in 2 weeks.
-There was a lab result, collected 3 weeks and 2 days later, dated 1/10/18, indicating an INR of 6.1.
-A subsequent physician order dated 1/10/18 to hold Coumadin for 2 nights then repeat INR in two days.
-There was a lab result, collected 9 days later, dated 1/19/18, indicating an INR of 3.9.

Interview with Resident #3 on 1/23/18 at 10:00am revealed:
-He took the blood thinner Coumadin, and amount changed often, he could not remember exactly how much he had been given.
-He always received medication every night and "everything was going well" as far as he knew.
-He had no recent bleeding, emergency room visits, or hospitalizations.
-Someone comes to take blood all the time, "I think I got it checked last Friday".

Interview with a second shift Medication Aide (MA) at 11:17am on 1/23/18 revealed:
-She never reviewed or processed lab orders for residents.
-She had received orders from the physician assistant in the past but could not recall the last order she processed for Resident #3's Coumadin.
-The Resident Care Coordinator (RCC) and Health and Wellness Director (HWD) would also notify MAs of changes at the beginning of the shift.

Interview with the Physician Assistant (PA) for Resident #3 on 1/23/17 at 12:06pm revealed:
-She had written orders for Resident #3's INR to be checked within two weeks on 12/18/17, however she understood results were late due to

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a holiday.
-She had written orders for Resident #3's INR to be checked within two days on 1/10/18, and she did not receive the results, therefore she called the facility last week to request results.
-She received the fax from the facility with lab results for 1/10/18 with the INR result of 6.1.
-She expected the facility to notify her with results as ordered.

Interview with a Customer Service Representative at the contracted laboratory at 2:41pm on 1/23/18 revealed:
-A phlebotomist was responsible for going to the facility to obtain lab work for Resident #3 when ordered.
-Results were collected and then faxed to the facility.
-The physician had no parameters indicated for when to contact her for critical results.
-The lab had guidelines for critical INR levels, if levels were 5.0 or higher the facility was notified via telephone call.
-The lab representative called and notified a staff member at the facility on 1/10/18 of INR level of 6.1.
-The last order for INR labs to be collected was received on 1/18/18.

Interview with the RCC at 3:00pm on 1/22/18 and 3:40pm on 1/23/18 revealed:
-She was responsible for ensuring lab orders were given to the lab and completed as ordered.
-Resident #3's INR levels were checked when ordered by the PA.
-A phlebotomist came to the facility to collect a sample for Resident #3.
-When results were received from the lab they were faxed to the PA for further instruction.
-Lab results were placed in the resident's record

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after being faxed to the PA.
-She was responsible for faxing lab results to the PA.
-The INR was not completed in two weeks as ordered on 12/18/17 because of a holiday and labs were normally completed on Mondays.
-The INR was not completed in two days as ordered on 1/10/18 because the phlebotomist did not come to collect sample.
-She was unsure why the labs were not collected by the phlebotomist.
-She did not contact the PA to inform that labs were not collected as ordered.
-The PA called requesting the results of the INR last week and the order was refaxed to the contracted laboratory on 1/18/18 to collect sample.
-She knew (H) meant high and (L) meant low as indicated on the lab results, but did not understand the critical levels and when to call the physician.
-She did not remember receiving a call from the contracted laboratory notifying Resident #3's INR level was critical on 1/10/18.
-She and the Medication Aides (MAs) were responsible for processing medication orders.
-New physician orders were faxed to the pharmacy and updated on the electronic medication administration record (eMAR).

Interview with the Health and Wellness Director (HWD) on 1/22/18 at 4:00pm and 1/23/18 at 3:40pm revealed:
-She expected the RCC to obtain laboratory orders from the physician and ensure they were faxed to the laboratory.
-She, MAs, and the RCC were responsible for receiving medication orders, faxing to the pharmacy, placing a copy in the record, and updating eMAR.

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D 273	Continued From page 4 -She expected staff to use the new order tracking form and had realized it had not be utilized as expected. -She and the RCC were both responsible for ensuring lab orders from the physician were processed. -The RCC was responsible for faxing lab results to the PA. -She did not know that labs were not completed as ordered until a call was received from the PA. -She contacted the contracted lab company and could not determine why labs were not collected as ordered. -Labs were normally collected every Monday for residents who had orders for labs. -She did not know Resident #3 had an INR of 6.1 on 1/10/18. -She never received a call from the lab to notify her that the lab was critical. -She expected the staff to check results and notify the PA and wait on a response. Interview with the Executive Director on 1/23/18 at 2:57pm revealed: -She did not know labs were not obtained as ordered for Resident #3 and the PA was not notified. -She expected staff to follow orders and follow-up with the PA if it could not be followed or if clarification was needed. -She expected the MAs, the RCC, and the HWD to ensure orders were implemented. -She would work with the RCC and HWD to ensure checks and balances were put in place.	D 273		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with	D 344		

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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, interviews, and record reviews, the facility failed to clarify an order for Coumadin dosage for 1 of 1 resident (Resident #3).

The findings are:

Review of Resident #3's current FL2 dated 7/20/17 revealed diagnoses included atrial fibrillation, cardiomyopathy, cardiac dysrhythmias, and hypotension.

Review of Resident #3's record revealed:
-A physician's order dated 12/18/17 for Coumadin 4mg every night except Saturday, administer 2mg on Saturday. (Coumadin is a medication used to prevent blood clots in medical conditions such as atrial fibrillation, pulmonary embolism, and deep vein thrombosis.)
-A subsequent physician order dated 1/10/18 to hold Coumadin for 2 nights then repeat INR in two days.
-A subsequent clarification order dated 1/22/18 to hold Coumadin dose tonight and resume

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Coumadin 4mg every night except Tuesday and Saturday. Will repeat INR in one week.

Review of Resident #3's January 2018 electronic Medication Administration Record (eMAR) revealed:
-An entry for Coumadin 2mg 1 tablet in the afternoon every Saturday at 4pm.
-An entry for Coumadin 4mg 1 tablet in the afternoon every Sunday, Monday, Tuesday, Wednesday, Thursday, and Friday at 4pm.
-Coumadin 2mg 1 tablet daily at 4pm was documented as administered on 1/6/18, 1/13/18, and 1/20/18.
-Coumadin 4mg 1 tablet daily at 4pm was documented as administered on 1/1/18-1/5/18, 1/7/18-1/9/18, 1/12/18, 1/14/18-1/19/18, 1/21/18-1/23/18

Interview with a second shift Medication Aide (MA) at 11:17am on 1/23/18 revealed:
-She never reviewed or processed lab orders for residents.
-When the Coumadin order was changed for Resident #3, it was put on the 24 hour report, faxed to the pharmacy, placed in the record, and changed in the computer system.
-The RCC and Health and Wellness Director (HWD) would also notify MAs of any changes at the beginning of the shift.
-She noticed Resident #3's Coumadin order changed frequently, and she administered as indicated in eMAR.

Interview with the Resident Care Coordinator (RCC) at 3:00pm on 1/22/18 and 3:40pm on 1/23/18 revealed:
-She and the Medication Aides (MAs) were responsible for processing medication orders.
-New physician orders were faxed to the

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pharmacy and updated in the computer system.
-She did not know why a new physician order was not obtained for Resident #3 on 1/12/18 after physician held the Coumadin for two days.
-She did not contact the PA to inform that labs were not collected as ordered.
-The PA called requesting the results of the INR last week and the order was refaxed to the contracted laboratory on 1/18/18 to collect sample.

Interview with the HWD on 1/23/18 at 9:15am revealed:
-"I spoke with [Resident #3's name] Physician Assistant yesterday evening."
-"She told us to hold last night's dose (1/22/18)."
-"But when we got the order it had already been given."
-"I called her back and she said she didn't want an INR until regular draw day (1/30/18)."
-She was going to hold tonight's dose (1/23/18) and she was going to change the administration time to 8pm.

Telephone interview with the facility pharmacy on 1/23/18 at 10:47am revealed:
-They had received an order for Resident #3 dated 12/18/17 for Coumadin 4mg 1 tablet daily except Saturday.
-They had dispensed 4 tablets of Coumadin 2mg on 1/11/18, 14 tablets of Coumadin 4mg on 1/7/18.
-They had received an order for Resident #3 dated 1/22/18 for Coumadin 4mg 1 tablet daily except Saturday and Tuesday, Saturday and Tuesday was for 2 mg.
-They had dispensed 8 tablets of Coumadin 2mg and 20 tablets of Coumadin 4mg on 1/22/18.

Interview with the PA for Resident #3 on 1/23/17

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D 344	Continued From page 8 at 12:06pm revealed: -She did not write another order for Coumadin as she was awaiting results of INR levels as ordered on 1/10/18. -Once she received INR results on 1/19/18, she provided a new order for Resident #3's Coumadin. -She was "ok" with Resident #3 continuing to receive the continued dose of 4mg every day except Saturday which was for 2mg Coumadin after it was held for two days. Second interview with the HWD on 1/22/18 at 4:00pm and 1/23/18 at 3:40pm revealed: -She, the MAs, and the RCC were responsible for receiving orders, faxing to the pharmacy, placing a copy in the record, and updating the eMAR. -She expected staff to use the new order tracking form and had realized it had not been utilized as expected. -She and the RCC were both responsible for ensuring orders from the physician were processed. -She did not know there were no orders for Resident #3's Coumadin after it was held on 1/10/18. -She believed since the order was not discontinued in the eMAR, the MAs continue to administer after the two day hold. Interview with the Executive Director on 1/23/18 at 2:57pm revealed: -She did not know there was no order for Resident #3's Coumadin after it was held on 1/10/18. -She expected staff to follow orders and follow-up with the PA if it could not be followed or if clarification was needed. -She expected with MAs, RCC, and HWD to ensure orders were implemented.	D 344		

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D 344	Continued From page 9 -She would work with the RCC and HWD to ensure checks and balances were put in place.	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: Based on observations, interviews, and record reviews, the facility failed to assure furosemide was administered as ordered for 1 of 8 residents (Resident #6) observed during medication administration. The findings are: Review of Resident #6's current FL2 dated 11/14/17 revealed diagnoses included Parkinson's Disease, atrial fibrillation, hypertension, and frequent falls. Review of Resident #6's order dated 1/11/18 revealed furosemide (used to treat edema) 20mg daily. Review of Resident #6's order dated 1/18/18 revealed "increase" furosemide to 40mg daily.	D 358		

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D 358	Continued From page 10 Observation of the 8:00am medication pass on 1/22/18 from 8:20am to 8:50am revealed at 8:48am, Staff A, Medication Aide (MA), administered 1 crushed tablet of furosemide 20mg in applesauce to Resident #6 along with the resident's other crushed oral medications. Review of Resident #6's January 2018 electronic Medication Administration Record (eMAR) revealed: -An entry for furosemide 20mg 1 tablet daily at 8:00am. -An entry for furosemide 40mg 1 tablet daily at 9:00am. -Furosemide 20mg 1 tablet daily at 8am was documented as administered from 1/12/18 to 1/18/18. -Furosemide 40mg 1 tablet daily at 9am was documented as administered from 1/19/18 to 1/22/18. Observation of Resident #6's medications available for administration on 1/22/18 at 11:00am revealed: -There was one bubble pack of furosemide 20mg tablets available on the medication cart. -The label on the furosemide 20mg tablets had a dispense date of 1/11/18 with a quantity of 30 tablets. -There were 23 tablets remaining in the bubble pack. -There were no furosemide 40mg tablets available on the medication cart for Resident #6. Interview with a MA on 1/22/18 at 11:01am revealed: -Resident #6's eMAR "does say 40mg" of furosemide daily. -"They must have changed that order on Friday (1/19/18)."	D 358		

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-"The computer says to give 1 tablet."
-Resident #6 "just has the one bubble pack of 20mg tablets" in the cart.
-"There's not a pack of 40mg tablets" available in the cart for Resident #6.

Interview with the Health and Wellness Director (HWD) on 1/22/18 at 4:30pm revealed:
-The Resident Care Coordinator (RCC) was "going to pull" Resident #6's bubble pack of furosemide 20mg tablets off the medication cart.
-The RCC had found a bubble pack of furosemide 40mg tablets available for Resident #6 in the facility overstock storage.
-The RCC was going to put the 40mg tablets on the medication cart, so they would be available for administration to Resident #6 starting 1/23/18.
-Medication Aides were "supposed to do their three checks" before administering a medication.
-They were trained to check the bubble pack to the eMAR, check the bubble pack label when "popping" the medication into the souffle cup, and check the bubble pack label before returning it to storage in the medication cart.
-When a new or change order was written for a medication, "whoever gets the order faxes it to the pharmacy, gets the fax confirmation, and then calls the pharmacy to make sure they got the order."
-The order was then entered into the eMAR system.
-An entry was also made in the 24 hr. report/shift to shift notes to ensure all staff were aware of the new or changed pending medication order.
-Third shift staff were responsible for ensuring new medications delivered by the pharmacy were stored on the appropriate medication cart and available for administration to the residents.
-At each shift change, the medication aides were supposed to verbally report medication changes

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D 358	Continued From page 12 to each other. Telephone interview with the facility pharmacy on 1/23/18 at 2:49pm revealed: -They had received an order for Resident #6 dated 1/11/18 for furosemide 20mg 1 tablet daily. -They had dispensed 30 tablets of furosemide 20mg on 1/11/18. -They had received an order for Resident #6 dated 1/18/18 for furosemide 40mg 1 tablet daily. -They had dispensed 30 tablets of furosemide 40mg on 1/18/18. Telephone interview with Resident #6's Physician's Assistant on 1/23/18 at 4:05pm revealed Resident #6 not getting the increased dose of furosemide on 1/22/18 "in this case was not detrimental to the resident" because Resident #6 furosemide was not given for a diagnosis of "heart failure." Observation of Resident #6's medications available on the medication cart on 1/23/18 at 4:08pm revealed: -There was one bubble pack of furosemide 40mg tablets available on the cart for Resident #6. -The label on the furosemide 40mg tablets had a dispense date of 1/18/18 with a quantity of 30 tablets. -There were 29 tablets remaining in the bubble pack. Interview with the RCC on 1/23/18 at 4:10pm revealed: -She did not know why the furosemide 40mg tablets sent out by the pharmacy on 1/18/18 had been stored in overstock instead of being added to Resident #6's medication storage area on the medication cart. -She did not know why the furosemide 20mg	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080014	A. BUILDING: _____ B. WING _____	C 01/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SALISBURY	2201 STATESVILLE BOULEVARD SALISBURY, NC 28147

(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 358	Continued From page 13 tablets had not been removed from the medication cart. Attempted interview with Resident #6 on 1/23/18 at 3:08pm was unsuccessful.	D 358		