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BROOKDALE EAST BROAD	2441 EAST BROAD STREET STATESVILLE, NC 28677

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 07/17/18-07/18/18.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: This area is still out of compliance. Based on observations, interviews, and record reviews, the facility failed to keep ceilings (resident rooms #20 and #26) and floor coverings (resident rooms #1, #3, #4, #5, #7, #12, #21 and #30) clean and in good repair. The findings are: Observations of the floors in resident rooms #1, #3, #4, #5, #7, #12, #21, and #30 on 07/17/18 between 9:40am and 10:30am at various intervals revealed: -All the rooms were covered in beige carpet. -Each room had numerous dark splotches, stains, smears and spots throughout the carpet in various places. Observations of the ceilings in resident rooms #20 and #26 on 07/17/18 between 9:40am and	D 074		

Reviewed and accepted by CD on 08/27/18

The following is a summary of the Plan of Correction for Brookdale East Broad. This Plan of Correction is in regards to the Corrective Action Report dated August 8, 2018. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

10A NCAC 13F .0306 Housekeeping and Furnishings
(a) Adult care homes shall:
(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;

- Designated room carpets were cleaned by 07/20/2018.
- Noted room carpets that continued to show stains have been measured for replacement.
- Designated ceilings have/will be repaired/painted as indicated.
- Going forward, room observations will be conducted on a routine basis by the Executive Director/Maintenance Director/Designee, for any needed maintenance needs no less than monthly.
- Rooms with noted concerns will be addressed when discovered.

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.

- Current resident charts have been reviewed for any order changes over the past 90 days and compared to their current MAR by the Health and Wellness Director/Executive Director/Designee.
- Any discrepancies noted were clarified with the resident physician at that time.
- Going forward, any new/changed order will have a "New Order Tracking" form completed at the time it was received.
- Each "New Order Tracking" form will be reviewed by the Health and Wellness Director/Executive Director/Designee daily for next 30 days, then minimally on a weekly basis thereafter.
- Re-training of appropriate associates on the use of the "New Order Tracking" form was completed on 7/25/18 by the Health and Wellness Director/Executive Director.
- A med-cart audit was completed on current residents by August 27, 2018, assuring medications are available for current orders by the Health and Wellness Director/Executive Director.
- Any noted discrepancies were obtained/followed up on at that time.
- Re-training of appropriate associates on steps to take when a medication is not available was completed on 7/25/18 by the Health and Wellness Director/Executive Director.
- Routine audits will be completed on the eMAR for unavailable medications, but at least on a weekly basis, by the Health and Wellness Director/Executive Director.

Lisette Melton, ED
8/27/18

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D 074	Continued From page 1 10:30am at various intervals revealed: -Room #20 had water stains on the ceiling in both the bedroom and bathroom. -Room #26 had a water stain on the ceiling in the bedroom. Interviews with residents on 07/18/18 between 11:15am and 3:00pm at various intervals revealed: -The resident's bedroom carpet had been shampooed "once in the ten months" the resident had lived at the facility. -The stains in the carpet looked better than they had in the past, but the carpet needed to be replaced because some of the stains could not be shampooed out. -The resident used a urinal at the bedside and urine would sometimes leak on the carpet. He had taken a medication about one month ago that turned his urine orange and it stained his carpet. The facility had "ran the carpet cleaner over it, but the stain was still there. I also tried to scrub it up." The carpet needed to be replaced. -Two residents had never seen the carpet in their room being shampooed. Review of professional carpet cleaning and carpet replacement invoices provided by the Administrator on 07/18/18 at 3:00pm revealed: -There was no invoice reflecting the carpet in Rooms #1 or #5 had been professionally cleaned. -The carpet in Room #3 had been professionally cleaned on 08/01/17, 01/16/18 and 05/08/18. -The carpet in Room #4 had been professionally cleaned on 08/01/17. -The carpet in Room #7 had been professionally cleaned on 08/01/17, 05/08/18 and 06/15/18. -The carpet in Room #12 had been professionally cleaned on 08/01/17, 01/16/18, 05/08/18, and 06/15/18.	D 074		

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D 074	Continued From page 2 -The carpet in Room #21 had been professionally cleaned on 08/01/17, 01/16/18, 05/08/18 and 06/15/18. -The carpet in Room #30 had been professionally cleaned on 06/15/18. -There was no invoice reflecting the carpet in Room #3 had been replaced. -The last time the carpet had been replaced in Room #1 was 04/10/14. -The last time the carpet had been replaced in Room #4 was 06/24/14. -The last time the carpet had been replaced in Room #5 was 06/06/17. -The last time the carpet had been replaced in Room #7 was 05/25/12. -The last time the carpet had been replaced in Room #12 was 03/14/10. -The last time the carpet had been replaced in Room #21 was 12/30/13. -The last time the carpet had been replaced in Room #30 was 12/30/15. Interview with the Maintenance Director on 07/18/18 at 8:10am revealed: -He worked twenty hours per week at this facility. -The facility had a contract with a professional carpet cleaning company that visited the facility once each quarter and shampooed the carpet in various locations. -He was responsible for shampooing the carpet on an "as needed basis" between the times the carpet cleaning company visited the facility. -He knew the carpet in various resident rooms had stains that could not be removed by shampooing the carpet. -He was responsible for repairing water leaks in the ceiling. -He used an application on his phone whereby the facility's management could notify him of maintenance needs.	D 074		

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D 074	Continued From page 3 -He did not know about the water stains on the ceiling in Rooms #20 and #26. Interview with the Administrator on 07/18/18 at 2:30pm revealed: -The facility had a contract with a professional carpet cleaning company and they visited the facility once each quarter. -The last time the carpet was professionally cleaned was in June 2018. -She was responsible for doing a "walk through" prior to each time the carpet cleaning company visited the facility to determine which rooms needed to be professionally cleaned. -Typically around ten residents' rooms were cleaned each visit. -The Maintenance Director was responsible for shampooing the carpet on an "as needed basis" between visits by the carpet cleaning company. -Carpet in some of the residents' rooms needed to be replaced because stains remained even after they were professionally shampooed. -"Corporate" only allowed replacement of the carpet when residents moved out. -She knew it had been awhile since the carpet had been replaced in Rooms #1 and #7 because those residents had lived there a long time. -The Maintenance Director was responsible for repairing water leaks in the ceiling. -She knew of the water stain in the ceiling of Room #20's bathroom, but had not made repairing it a priority because the room was currently unoccupied. -She did not know about the water stain in the ceiling of Room #20's bedroom or Room #26's bedroom.	D 074		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 4 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, record reviews, and interviews, the facility failed to administer medications as prescribed by a licensed prescribing practitioner for two of five sampled residents who had errors related to pain medication (Resident #1) and eye drops (Resident #5). The findings are: 1. Review of Resident #1's current FL-2 dated 04/24/18 revealed: -Diagnoses included diabetes and end stage renal disease. -There was an order for Norco 5/325 mg (an opioid pain medication) take one tablet every four hours for pain as needed. Review of Resident #1's record revealed a signed subsequent physician order dated 06/28/18 "Hold Norco try tramadol, tramadol 50 mg (a non-narcotic pain medication) every 8 hours as needed for pain." Review of Resident #1's electronic Medication Administration Record (eMAR) for June 2018	D 358		

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D 358	Continued From page 5 revealed: -There was an entry for Norco 5/325 mg every eight hours as needed for pain. -There was documented entry Norco 5/325mg had been administered on 06/29/18 at 7:12pm and on 6/30/18 at 2:26am. -There was not an entry for tramadol 50 mg take one every 8 hours as needed for pain. Review of Resident #1's eMAR for July 2018 revealed: -There was an entry for Norco 5/325 mg every eight hours for pain as needed. -There was documented entry Norco 5/325mg had been administered 16 times from 07/01/18 to 07/17/18. -There was not an entry for tramadol 50 mg take one every 8 hours as needed for pain. Observation of medications on hand revealed there were no tramadol 50 mg available for Resident # 1. Telephone interview with the facility pharmacy on 07/17/18 at 2:30pm revealed: -They had not received the physician order dated 06/28/18 to hold Norco 5/325 mg try tramadol; tramadol 50 mg every 8 hours as needed for pain. -The facility was responsible for faxing orders to the pharmacy. Telephone interview with Resident #1's physician on 07/17/18 at 3:15pm revealed: -He had written the order for Resident #1 on 06/28/18 to hold the Norco 5/325 mg and then try tramadol 50 mg every 8 hours as needed. -His expectations were to wean Resident #1 off the Norco and to taper to then tramadol 50 mg. -"The Norco is habit forming."	D 358		

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D 358	Continued From page 6 -He did not know the facility had not administered the tramadol as needed to Resident #1. -He did not know the facility staff had administered Norco 5/325 mg 2 times in June 2018 and 16 times in July 2018 after he had written the order dated 06/28/18 to hold Norco and try tramadol. -He had wanted Resident #1 to transition off Norco 5/325 mg and to start tramadol 50 mg every 8 hours as needed. Interview with the Health and Wellness Director (HWD) on 07/17/18 at 3:30pm revealed: -The medication aides (MA) were responsible for faxing new orders to the pharmacy. -He had not seen the order for Resident #1 dated 06/28/18. -The order had probably been "overlooked." -He would immediately fax Resident #1's order to the pharmacy. Interview with Resident #1 on 07/17/18 at 4:05pm revealed she had never tried tramadol 50 mg, and was unsure if it would have helped her pain or not. Interview with a MA on 07/18/18 at 7:35am revealed: -When the MAs got a physician order they were to fax the order to the pharmacy. -The MAs were to complete a tracking form with all orders to assure the orders were faxed to the pharmacy. -The tracking form was attached to the order after the order was faxed to the pharmacy. -The order and the tracking form were to be placed in the resident's record. -A copy of the order and the tracking form were placed in a review folder for the HWD to review. -The pharmacy would send the medications after	D 358		

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D 358	Continued From page 7 two MAs verified the order was correct on the eMAR. -She had not seen Resident #1's order dated 06/28/18 to hold the Norco and try tramadol. -She was not sure why the order had not been faxed to the pharmacy, "It must have been overlooked." Interview with a second MA on 07/18/18 at 11:08am revealed: -She had worked as a MA on 06/28/18. -Resident #1 had an appointment on 06/28/18 and her family had taken her to the physician's office. -The physician had faxed an order to the facility on 06/28/18 before Resident #1 had returned from the appointment to decrease another medication for Resident #1. -She assumed that was all the changes to Resident #1 medications the physician had ordered. -She had not faxed the order dated 06/28/18 the family had given her for Resident #1 to the pharmacy. -She had not completed a tracking form for the order dated 06/28/18. -"I guess I overlooked the pain med order." Interview with the Administrator on 07/18/18 at 2:20pm revealed: -She did not know Resident #1 had an order dated 06/28/18 to hold Norco and try tramadol. -She relied on the MA to fax the orders to the pharmacy and complete a tracking form for each order. -The HWD was to follow up with the MAs to assure new orders were completed. Interview with the Administrator on 07/18/18 at 2:45pm revealed:	D 358		

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D 358	Continued From page 8 -The MAs were responsible for faxing the orders to the pharmacy and completing a tracking form. -The tracking form was not a new form; it had been used in the facility for several years. -The MAs were all trained upon hire on using the tracking form for all orders. -She would schedule re-training for all MAs on the order process and documentation using the tracking log form. -The HWD would be responsible for reviewing all resident orders and assuring tracking forms were completed. -She would follow up with the HWD and the MAs for completion of all orders using the tracking log form. 2. Review of Resident #5's current FL2 dated 01/19/18 revealed: -Diagnoses included dementia, gastroesophageal reflux disease, and chronic obstructive pulmonary disease. -There was a physician's order for artificial tears 0.4% instill 1 drop in both eyes 3 times daily (artificial tears are eye drops used to treat dry eyes). Review of Resident #5's Physician Order Sheet dated 01/28/18 revealed an order for artificial tears 0.4% instill 1 drop in both eyes 3 times daily with no subsequent orders found in the chart. Review of Resident #5's May 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for artificial tears 0.4% instill 1 drop in both eyes three times a day for dry eyes. -Artificial tears was documented as administered three times daily from 05/01/18 to 05/31/18 at 9:00am, 2:00pm and 9:00pm except on 05/17/18 at 02:00pm where it was documented that	D 358		

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D 358	Continued From page 9 Resident #5 was out of the facility. Review of Resident #5's June 2018 eMAR revealed: -There was a computer generated entry for artificial tears 0.4% instill 1 drop in both eyes three times a day for dry eyes. -Artificial tears were documented as administered three times daily from 06/01/18 to 06/30/18 at 9:00am, 2:00pm and 9:00pm. Review of Resident #5's July 2018 eMAR revealed: -There was a computer generated entry for artificial tears 0.4% instill 1 drop in both eyes three times a day for dry eyes. -Artificial tears was documented as administered three times daily from 07/01/18 to 07/17/18 at 9:00am, 2:00pm and 9:00pm except for 6 doses during this time where it was documented to see nurses notes (07/03/18 at 9:00am and 9:00pm, 07/06/18 at 9:00pm, 07/16/18 at 9:00pm, 07/17/18 at 9:00am and 9:00pm). -Artificial tears was documented as administered on 07/18/18 at 9:00am. -Nurses notes were not included on the printed copy. Observation of Resident #5's medications on hand on 07/18/18 at 10:39am revealed no artificial tears were available to be administered to the resident. Interview with a medication aide (MA) on 07/18/18 at 10:39am revealed: -She did not administer any artificial tears to Resident #5 on the morning of 07/18/18. -She did not know why the medication was not on the cart for the resident and she did not try to find out why.	D 358		

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D 358	Continued From page 10 Interview with Resident #5 on 07/18/18 at 11:35am revealed she received her eye drops "most of the time but I do remember missing some doses." Interview with the Administrator on 07/18/18 at 2:56pm revealed the reason Resident #5 missed 6 doses during July 2018 was because the medication was on order from the pharmacy. Telephone interview with a pharmacy technician from the contracted facility pharmacy on 07/18/18 at 11:07am revealed: -A 15 ml bottle of artificial tears was dispensed to Resident #5 on 02/13/18 with the directions instill 1 drop to both eyes three times daily. -A 15 ml bottle of artificial tears would have a 50 days' supply lasting to approximately 04/04/18. -The facility had tried to order the medication on 07/17/18 but the "product is on a nationwide shortage and is not available." -"A staff member had tried to call the facility at 6:12pm on 07/17/18 to let them know but no one answered the phone." Telephone interview with Resident #5's primary care provider (PCP) on 07/18/18 at 3:08pm revealed: -Resident #3 "may experience worsening of her dry eyes, an infection or irritation if she missed several doses of the artificial tears." -He was not aware that the resident had only been dispensed 1 bottle of eye drops during the past five months. -He would do his best to make sure the resident was able to continue receiving her medication if he had to change the order for the artificial tears.	D 358		