PRINTED: 11/01/2018
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011035	A. BUILDING: _____ B. WING _____	10/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ASHEVILLE WALDEN RIDGE	4 WALDEN RIDGE DRIVE ASHEVILLE, NC 28803

(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 and the Buncombe County Department of Social Services conducted an annual survey on 10/25/18 and 10/26/18.	D 000		
D 354	10A NCAC 13F .1003 (c) Medication Labels 10A NCAC 13F .1003 Medication Labels (c) The facility shall assure the container is relabeled by a licensed pharmacist or a dispensing practitioner at the refilling of the medication when there is a change in the directions by the prescriber. The facility shall have a procedure for identifying direction changes until the container is correctly labeled. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication containers had correct labels for 1 of 3 sampled residents (Resident #2) related to allopurinol, mirtazapine, and fexofenadine. The findings are: Review of Resident #2's current FL2 dated 02/26/18 revealed: -Diagnoses included Alzheimer's disease, gout,	D 354		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Allison Bridges RN | TITLE: Interim ED | (X6) DATE: 11/8/2018

REVIEWED & accepted 11/9/18 CF

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D 354	Continued From page 1 and acute bronchitis. -There was a physician's order allopurinol (reduces uric acid) 150mg daily. a. Review of a physician's order dated 03/03/17 revealed an order for allopurinol 300mg daily. Review of a physician's order dated 08/19/18 revealed an order for allopurinol 150mg daily. Observation on 10/25/18 at 3:11pm of Resident #2's medications on hand revealed : -One bubble pack labeled allopurinol 300mg take one tablet daily. -Thirty tablets were dispensed on 10/13/18. -There were 22 whole tablets remaining in the bubble pack. -There was no change of direction sticker or indication that directions were wrong on the bubble pack. Review of Resident #2's September and October 2018 electronic Medication Administration Record (eMAR) revealed: -There was a entry for allopurinol 150mg one time daily. -There was documentation that the correct dose had been administered. Interview on 10/25/18 at 3:30pm with the facility's contracted pharmacy revealed: -The pharmacy received a faxed order on 03/06/17 for allopurinol 300mg daily. -They had last dispensed 30 tablets of allopurinol 300mg on 10/10/18. -They had no other orders for allopurinol. Refer to the interview on 10/25/18 at 3:20pm with a first shift Medication Aide.	D 354		

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D 354	Continued From page 2 Refer to the interview on 10/26/18 at 7:35am with a second first shift Medication Alde. Refer to the interview on 10/26/18 at 9:15am with the Resident Care Coordinator. Refer to the interview on 10/25/18 at 3:40pm with the Health and Wellness Director. b. Review of a physician's order dated 03/26/18 revealed an order for mirtazapine (antidepressant) 7.5mg daily at bedtime. Review of a physician's order dated 04/03/18 revealed an order for mirtazapine 15mg daily at bedtime. Review of a physician's order dated 08/09/18 revealed an order for mirtazapine 7.5mg daily at bedtime. Observation on 10/25/18 at 3:14pm of Resident #2's medications on hand revealed: -One bubble pack labeled mirtazapine 15mg take one tablet every night at bedtime. -Thirty tablets were dispensed on 10/13/18. -There were 22 whole tablets remaining in the bubble pack. -There was no change of direction sticker or indication that directions were wrong on the bubble pack. Review of Resident #2's September and October 2018 eMAR revealed: -There was an entry for mirtazapine 15mg tablet, take 0.5 (7.5mg) tablet at bedtime. -There was documentation that the correct dose had been administered. Interview on 10/25/18 at 3:30pm with the facility's	D 354		

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D 354	Continued From page 3 contracted pharmacy revealed: -The pharmacy had received a faxed order on 04/05/18 for mirtazapine 15mg every day at bedtime. -30 tablets were dispensed on 10/10/18. -The pharmacy had no other mirtazapine orders. Review of a physician's order dated 10/24/18 revealed the mirtazapine was discontinued. Refer to the interview on 10/25/18 at 3:20pm with a first shift Medication Aide. Refer to the interview on 10/26/18 at 7:35am with a second first shift Medication Aide. Refer to the interview on 10/26/18 at 9:15am with the Resident Care Coordinator. Refer to the interview on 10/15/18 at 3:40pm with the Health and Wellness Director. c. Review of a physician's order dated 04/30/18 revealed an order for fexofenadine (antihistamine) 60mg two times daily. Review of a physician's order dated 05/01/18 revealed an order for fexofenadine 30mg two times daily. Review of a physician's order dated 08/09/18 revealed an order for fexofenadine 30mg two times daily. Observation on 10/25/18 at 3:10pm of Resident #2's medications on hand revealed: -A bubble pack of fexofenadine 60mg tablets, take one tablet twice daily. -30 tablets were dispensed on 10/13/18 and 22 whole tablets remained in the bubble pack.	D 354		

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D 354	Continued From page 4 -A second bubble pack of fexofenadine 60 mg tablets, take one tablet twice daily. -30 tablets were dispensed on 10/13/18 and 22 whole tablets remained in the bubble pack. -There was no change of direction sticker or indication that directions were wrong on the bubble pack. Review of Resident #2's September and October 2018 eMAR revealed: -There was an entry for fexofenadine 30mg tablet, take one tablet two times daily. -There was documentation that the correct dose had been administered. Interview on 10/25/18 at 3:30pm with the facility's contracted pharmacy revealed: -The pharmacy had received a faxed order on 04/30/18 for fexofenadine 60mg two times daily. -60 tablets were dispensed on 10/10/18. -The pharmacy had no other fexofenadine orders. Review of a physician's order dated 10/24/18 revealed the fexofenadine was discontinued. Refer to the interview on 10/25/18 at 3:20pm with a first shift Medication Aide. Refer to the interview on 10/26/18 at 7:35am with a second first shift Medication Aide. Refer to the interview on 10/26/18 at 9:15am with the Resident Care Coordinator. Refer to the interview on 10/25/18 at 3:40pm with the Health and Wellness Director. Interview on 10/25/18 at 3:20pm with a first shift Medication Aide (MA) revealed: -The MA knew the labels on the bubble packs of	D 354		

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D 354	Continued From page 5 medications were not correct. -The MA would use a pill cutter to cut the tablets in half. -Resident #2 was getting the correct dose of medications. -The MA did not know why the correct dose of medications had not been sent by the pharmacy. -The MA did not know why the bubble packs did not have a change in direction sticker on them. -"Some times we have trouble with the pharmacy." Interview on 10/26/18 at 7:35am with a second first shift MA revealed: -The MA would "split" the tablet to make sure Resident #2 received the correct dose of medication. -MAs faxed new orders to the pharmacy. -The bubble packs should have a change in direction or dose sticker on them. Interview on 10/26/18 at 9:15am with the Resident Care Coordinator (RCC) revealed: -There should have been a change in direction sticker on the medications. -The MA would "put the sticker on the med (medication) when they get the order". -New orders were entered into the computer by the Health and Wellness Director (HWD) or a MA. -The third shift MA was responsible for comparing new bubble packs with the orders on the eMAR. -The change in direction stickers for Resident #2's medications were "overlooked". Interview on 10/25/18 at 3:40pm with the HWD revealed: -All new orders were faxed to the pharmacy. -The HWD or MA entered medications into the eMAR system.	D 354		

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D 354	Continued From page 6 -"The pharmacy doesn't have that capacity." -She did not know why change in direction stickers had not been put on the bubble packs. -The third shift MA compared new bubble packs with the orders on the eMAR. -She knew the MAs were splitting the medications to give the correct dose.	D 354		

The following is the Plan of Correction for **Brookdale Asheville Walden Ridge.** This Plan of Correction is in regards to the Statement of Deficiencies dated 11-1-2018. 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 .1003 (c)- Medication Labels

- On October 25th 2018, a request for clarification of medication orders was made to Resident #2's primary care physician. Orders were received to discontinue Fexofenadine and Mirtazapine from the resident's medication regimen. Medications were removed from the medication cart upon receipt of the orders to discontinue the medications.
- On October 25th 2018, a "change in direction – see resident record" sticker was placed on Resident #2's Allopurinol pack to indicate a change in dosage. The order for Allopurinol 150mg was faxed to the pharmacy for re-order and delivery.
- On October 26th 2018, a supply of Allopurinol 150mg tablets was received for Resident #2.
- On October 31st 2018, Neil Medical Pharmacy conducted a quarterly monitoring review of resident's medications and current orders.
- On November 3rd 2018, the Health and Wellness Director, Resident Care Coordinator and Supervisor completed a community wide Medication Cart, Medication Administration Record and Medication Order audit to verify compliance. Audits will continue monthly during cycle fill and as needed to verify compliance.
- The Health and Wellness Director and/or Resident Care Coordinator will re-train Med Techs on processing and clarifying physician orders, including the procedure for indicating medication dosage changes. Training will be completed by November 10th 2018 and will continue annually thereafter.
- The New Order Checklist will track new physician order processing including order clarification, transcription, application of "change in direction" stickers and receipt of medications.
- The Health and Wellness Director, Resident Care Coordinator and/or Designee will review New Order Checklists to monitor accuracy and receipt of medications. Monitoring will be on going.

Signature: Allison Bridges, RN

Date: 11/8/2018