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	HAL036015	A. BUILDING: _____ B. WING _____	12/19/2018

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BROOKDALE ROBINWOOD	1750 ROBINWOOD ROAD GASTONIA, NC 28054

(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 an annual survey on December 18-19, 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 observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents (Resident #3) regarding elevated finger stick blood sugars (FSBS). The findings are: Review of Resident #3's current FL2 dated 02/05/18 revealed diagnoses included uncontrolled diabetes mellitus related to non-compliance. Review of a physicians order for Resident #3 dated 11/07/18 revealed was to monitor FSBS before meals and at bedtime and to contact the endocrinologist if the FSBS were less than 60 or greater than 300 for 3 consecutive checks. Review of Resident #3's November 2018 electronic Medication Administration Record (eMAR) revealed:	D 273		

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D 273	Continued From page 1 -There was an entry to monitor FSBS before meals and at bedtime and to contact the endocrinologist if the FSBS were less than 60 or greater than 300 for 3 consecutive checks. -The blood sugar was documented on 11/18/18 at 12:00pm as 406. -The blood sugar was documented on 11/18/18 at 5:00pm as 543. -The blood sugar was documented on 11/18/18 at 9:00pm as 395. -There had been no documentation the physician had been notified about Resident #3's FSBS being greater than 300. Review of Resident #3's December 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry to monitor FSBS before meals and at bedtime and to contact endocrinology if the FSBS were less than 60 or greater than 300 for 3 consecutive checks. -The blood sugar was documented on 12/13/18 at 5:00pm as 564. -The blood sugar was documented on 12/13/18 at 9:00pm as 531. -The blood sugar was documented on 12/14/18 at 8:30am as 313. -There was no documentation the physician had been notified about Resident #3's FSBS being greater than 300. Review of the progress notes for Resident #3 revealed there was no documentation the endocrinologist was notified about the elevated FSBS on 11/18/18, 12/13/18, or 12/14/18. Interview with the medication aide (MA) on 12/19/18 at 10:20am revealed: -She knew that Resident #3 had FSBS greater than 300 at times.	D 273		

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-She knew the parameters for Resident #3 which required notification of the endocrinologist for FSBS greater than 300 or less than 60 for three consecutive checks.
-She had not been able to review Resident #3's FSBS in the eMAR because when she had tried to access the history the system it would not let her view the previous readings for the dates prior to her checking the FSBS.
-She had recognized during the observation of the medication pass she was not able to review the FSBS history for Resident #3.
-She had not told the Health and Wellness Nurse she could not review the history of the FSBS for Resident #3.
-It would have been her responsibility to notify the endocrinologist.
-She had not contacted the endocrinologist.

Interview with the Health and Wellness Nurse on 12/19/18 at 11:00am revealed:
-It was the responsibility of the MA to call the endocrinologist about Resident #3's FSBS.
-The MAs had been trained on how to review the eMAR history to compare the FSBS.
-She was not sure why Resident #3's FSBS had been overlooked.
-It was her responsibility to review the eMARs to ensure the MAs were doing what the orders said.
-She had looked in Resident #3's record and did not find a progress note that someone had notified the endocrinologist.
-She had called the endocrinologist's office and they had told her no one had contacted their office to notify them.

Interview with Resident #3's endocrinologist office nurse on 12/19/18 at 10:40am revealed:
-There was no communication to the endocrinologist of Resident #3's FSBS.

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D 273	Continued From page 3 -The last communication from the facility was made on 11/22/18 to request a hold for Resident #3's insulin for a FSBS of 51. -The endocrinologist had last seen Resident #3 on 11/07/18. -The endocrinologist was monitoring Resident #3 closely because he was non-compliant with medication, and had been hospitalized in October due to his blood sugars. Interview with the Administrator on 12/19/18 at 11:00am revealed: -She expected the MAs to notify the endocrinologist about Resident #3's FSBS. -She was concerned that the MAs might have been having an issue with the eMAR history of orders for three consecutive FSBS. -She felt this occurrence was a system fail because the MAs did not review all of the previous FSBS. -The Health and Wellness Nurse or the Resident Care Coordinator should have been made aware the MA could not review the FSBS. -The Health and Wellness Nurse and the Resident Care Coordinator were responsible to provide oversight for the MAs.	D 273		
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.	D 358		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medication as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (Resident #1, #4, and #5) related to administering the incorrect dose of vitamin D (Resident #1) and Toviaz (Resident #4), discontinuing Toprol with an order (Resident #1), and not administering Flonase (Resident #5).

The findings are:

1. Review of Resident #1's current FL2 dated 11/21/18 revealed diagnoses included diabetes, congestive heart failure, and hypothyroidism.

a. Review of Resident #1's physician's order dated 04/08/18 revealed a physician's order for Toprol XL 25mg take 2 tablets daily for 30 days (used to treat high blood pressure and irregular heart rhythms).

Review of Resident #1's physician's order revealed a physician's order dated 05/08/18 for Toprol XL 50mg take 1 tablet daily for 30 days with an additional refill.

Review of Resident #1's October, November, and December 2018 eMAR revealed no computer generated entry for Toprol XL 50mg.

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D 358	Continued From page 5 Interview with Resident #1 on 12/18/18 at 10:40am revealed: -He felt like he was not getting his medication at the right times. -He felt like he was not getting all of his medications, but could not elaborate on which ones he was missing. -He used to administer his own medications, but had to give it up due to his ageing. -He felt like he was getting more medications when he was taking them himself. Interview with a pharmacy technician from the facility's contracted pharmacy on 12/19/18 at 10:49am revealed: -The physician's order for Toprol XL 50mg was written on 05/16/18. -There were 30 tablets of Toprol XL 50mg dispensed to Resident #1 on 05/09/18, 08/17/18, and 10/02/18 with the directions take 1 tablet daily. -Based on the refill history for Toprol XL, Resident #1 was out of medication after 10/31/18. -The facility staff was responsible for requesting medication refills. -The pharmacy did not have an order to discontinue Toprol. Observation of Resident #1's medications on hand on 12/18/18 at 3:17pm revealed there was no Toprol XL available to be administered. Review of the facility's Medication Administration Policy revealed all medications should be administered based on physician's orders. Interview with a first shift MA on 12/19/18 at 8:19am revealed: -She worked first shift and administered Resident	D 358		

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D 358	Continued From page 6 #1's morning medications. -She remembered administering Toprol to Resident #1 but could not remember when it stopped being available to administer. -She was not sure why Toprol was no longer available to be administered to Resident #1. -The MAs were responsible for entering new physician orders into the eMAR. -She was responsible for comparing the label on each medication to the eMAR to make sure they matched before administering medication. -The MAs were responsible for removing discontinued medications from the medication cart. -The MAs were responsible for completing a 24 hour report daily that was used to communicate medication changes to the MA for the next shift. Interview with the RCC on 12/19/18 at 12:46pm revealed: -The physician's order for Toprol stated for 30 days. -The medication was discontinued and removed from Resident #1's eMAR after 30 days from the date the order was written on 06/09/18. -She did not clarify with Resident #1's cardiologist if the resident should continue taking the Toprol. -She or the MAs were responsible for getting clarification from the provider if a discrepancy was identified. -She did not think the Toprol order needed a clarification. -The MAs were responsible for order entry into the eMAR software. -She was responsible for making sure the MAs had entered all new medication orders into the eMAR correctly. -The MAs were responsible for making sure the pharmacy dispensed the correct medication to the residents.	D 358		

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-The MAs were responsible for making sure the label on the medication matched the entry on the eMAR.

Interview with the HWD on 12/18/18 at 3:49pm and on 12/19/18 at 8:15am revealed:
-She did not think Resident #1 should be taking Toprol because the physician's order was "for 30 days."
-The MAs were responsible for entering all new medication orders into the eMAR and faxing the order to the pharmacy.
-The MAs would fill out a new order tracking form and put the form in the RCC's box to review.

Interview with Resident #1's PCP on 12/19/18 at 11:14am revealed:
-Toprol XL 25mg take 2 tablets daily was listed on Resident #1's list of active medications list.
-Resident #1 was prescribed by his cardiologist.
-She did not know if Resident #1's cardiologist had discontinued the Toprol.

Interview with the Administrator on 12/19/18 at 1:10pm revealed:
-Residents should be receiving medications based on physician's orders.
-The MAs were responsible for comparing the medication label to the eMAR before they administered medication to a resident.
-There should be two facility staff reviewing all medication orders and the eMAR to make sure orders were entered correctly.
-The MAs were responsible for entering new medication orders on the eMAR and filling out a new order tracking form for the RCC or HWD to review.
-The RCC and HWD were responsible for completing monthly random record audits that included comparing the eMARs to the medication

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in the cart and comparing the eMARs to new medication orders.
-The MAs, RCC, or HWD were responsible for clarifying and correcting any discrepancies.
-She did not know why the Toprol order was not clarified to determine if the medication should be continued past 30 days from the date the order was written.
-The MAs were responsible for medication administration to the residents.

Attempted telephone interview with Resident #1's cardiologist on 12/19/18 at 9:28am was unsuccessful.

b. Review of Resident #1's current FL2 dated 11/21/18 revealed there was a physician's order for vitamin D 1,000 IU take 1 tablet daily (supplement used to treat vitamin D deficiency).

Review of Resident #1's physician's order dated 07/28/18 revealed a physician's order for vitamin D 800 IU take 1 tablet daily.

Review of Resident #1's physician's order dated 11/08/18 revealed a clarification order signed by Resident #1's primary care physician (PCP) to discontinue vitamin D 800 IU and continue vitamin D 1,000 IU take 1 tablet daily.

Review of Resident #1's October 2018 electronic Medication Administration Record (eMAR) revealed:
-There was a computer generated entry for vitamin D 1,000 IU take 1 tablet daily scheduled to be administered at 9:00am.
-Vitamin D 1,000 IU was documented as administered from 10/01/18 to 10/31/18, except on 10/22/18 and 10/29/18.
-There was a computer generated entry for

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vitamin D 400 IU take 2 tablets (800 IU) daily scheduled to be administered at 8:00am and was documented as administered from 10/10/18 to 10/31/18, except on 10/29/18.
-Resident #1 was out of the facility at the hospital on 10/29/18.

Review of Resident #1's November 2018 eMAR revealed:
-There was a computer generated entry for vitamin D 1,000 IU take 1 tablet daily scheduled to be administered at 9:00am.
-Vitamin D 1,000 IU was documented as administered from 11/01/18 to 11/30/18.
-There was a computer generated entry for vitamin D 400 IU take 2 tablets (800 IU) daily with a scheduled to be administered at 8:00am.
-Vitamin D 400 IU was documented as administered from 11/01/18 to 11/09/18.

Review of Resident #1's December 2018 eMAR revealed:
-There was a computer generated entry for vitamin D 1,000 IU take 1 tablet daily scheduled to be administered at 9:00am.
-Vitamin D 1,000 IU was documented as administered from 12/01/18 to 12/18/18.

Observation of Resident #1's medications on hand on 12/18/18 at 3:17pm revealed:
-There were 2 medication cards of vitamin D 400 IU available to be administered to Resident #1.
-There was a medication card of vitamin D 400 IU dispensed on 11/08/18 with 2 tablets remaining to be administer to Resident #1.
-There was a new medication card of vitamin D 400 IU containing 60 tablets dispensed to Resident #1 on 12/06/18 with no tablets removed.
-Each bubble on the medication card contained 2 tablets to equal 800 IU per dose.

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D 358	Continued From page 10 -There was no vitamin D 1,000 IU available to be administered to Resident #1. Interview with Resident #1 on 12/18/18 at 10:40am revealed: -He felt like he was not getting his medication at the right times. -He felt like he was not getting all of his medications, but could not elaborate on which ones he was missing. -He used to administer his own medications, but had to give it up. -He felt like he was getting more medications when he was taking them himself. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/19/18 at 10:49am revealed: -A 30 day supply of vitamin D 1,000 IU was last dispensed to Resident #1 on 07/27/18 and the physician's order had been discontinued on 10/10/18. -A 30 day supply of vitamin D 400 IU was dispensed to Resident #1 on 11/03/18 and 12/06/18. -The pharmacy did not have a discontinuation order for vitamin D 400 IU dated 11/08/18. -The pharmacy was not able to view orders the facility was entering into their eMAR software. -The pharmacy entered medication orders they received from the facility and dispensed the medication to the residents. Review of the facility's Medication Administration Policy revealed all medications should be administered based on physician's orders. Interview with a first shift medication aide (MA) on 12/19/18 at 8:19am revealed: -She worked first shift and administered Resident	D 358		

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#1's morning medications.
-She administered 2 tablets of the vitamin D 400 IU to Resident #1 every morning.
-She did not know Resident #1's physician order for 400 IU had been discontinued and he had been continued on vitamin D 1,000 IU.
-The MAs were responsible for inputting new physician orders into the eMAR.
-She was responsible for comparing the label on each medication to the eMAR to make sure they matched before administering medication.
-The MAs were responsible for removing discontinued medications from the medication cart.
-The MAs were responsible for completing a 24 hour report daily that was used to communicate medication changes to the MA for the next shift.

Interview with a second shift MA on 12/18/19 at 3:17pm revealed:
-She did not know Resident #1's physician order for 400 IU had been discontinued and he had been continued on vitamin D 1,000 IU.
-The MAs were responsible for inputting new physician orders into the eMAR software.
-The Resident Care Coordinator (RCC) or the Health and Wellness Direction (HWD) were responsible for removing discontinued medications from the medication cart.

Interview with the RCC on 12/19/18 at 12:46pm revealed:
-She did not know Resident #1 was receiving the incorrect dose of vitamin D.
-She did not remember seeing the order to change the vitamin D order.
-The MAs were responsible for order entries into the eMAR.
-She was responsible for making sure the MAs had entered all new medication orders into the

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eMAR software correctly.
-The MAs were responsible for making sure the pharmacy dispensed the correct medication to the facility.
-The MAs were responsible for making sure the label on the medication matched the entry on the eMAR.
-She or the MAs were responsible for getting clarification from the provider if a discrepancy was identified.

Interview with the HWD on 12/18/18 at 3:49pm and on 12/19/18 at 8:15am revealed:
-She did not know Resident #1 was receiving the incorrect vitamin D dose.
-She did not know about Resident #1's vitamin D medication orders.
-The MAs were responsible for inputting all new medication orders into the eMAR and faxing the order to the pharmacy.
-The MAs would fill out a new order tracking form and put the form in the RCC's box to review.
-The RCC was responsible for checking the order entry for accuracy.

Interview with Resident #1's PCP on 12/19/18 at 11:14am revealed:
-Resident #1 should be administered vitamin D 1,000 take 1 tablet daily.
-She did not know Resident #1 was receiving the incorrect dose of vitamin D.

Interview with the Administrator on 12/19/18 at 1:10pm revealed:
-Residents should be receiving medications based on physician's orders.
-The MAs were responsible for comparing the medication label to the eMAR before they administered medication to a resident.
-There should be two facility staff reviewing all

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medication orders and the eMAR to make sure orders were entered correctly.
-The MAs were responsible for inputting new medication orders on the eMAR and filling out a new order tracking form for the RCC or HWD to review.
-The RCC and HWD should be comparing eMAR to the medication orders.
-The MAs were responsible for removing discontinued medications from the medication cart.
-The RCC and HWD were responsible for completing monthly random record audits that included comparing the eMARs to the medication in the cart and comparing the eMARs to new medication orders.
-The MAs, RCC, or HWD were responsible for clarifying and correcting any discrepancies.
-The MAs were responsible for medication administration to the residents.

2. Review of Resident #4's current FL2 dated 09/28/18 revealed:
-Diagnoses included dementia, urinary tract infections and atrial fibrillation.
-An order for Toviaz ER (a medication used to treat and over active bladder) 8mg every day.
-Resident #4 was incontinent of bowel and bladder.

Review of Resident #4's record revealed a subsequence physician's order for Toviaz 8mg every day dated 10/18/18.

Review of Resident #4's October 2018 electronic Medication Administration Record (eMAR) revealed:
-There was a computer generated entry for Toviaz 4mg every day scheduled to be

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administered at 10:00am.
-Toviaz 4mg ER was documented as administered from 10/06/18 to 10/31/18 at 10:00am.
-Resident #4 was out of the facility on 10/01/18 - 10/05/18.

Review of Resident #4's November 2018 eMAR revealed:
-There was a computer generated entry for Toviaz 4mg every day scheduled to be administered at 10:00am.
-Toviaz 4mg ER was documented as administered from 11/01/18 to 11/16/18 at 10:00am.
-Toviaz 4mg ER was documented as administered from 11/16/18 to 11/30/18 at 10:00am.

Review of Resident #4's December 2018 eMAR revealed:
-There was a computer generated entry for Toviaz 4mg every day scheduled to be administered at 8:00am.
-Toviaz 4mg ER was documented as administered from 12/01/18 to 11/19/18 at 8:00am.

Observation of Resident #4's medications on hand on 12/19/18 at 09:00am revealed:
-There was 1 medication card from a pharmacy dated 10/05/18, Toviaz 4mg ER 30 tablets every day available to be administered to Resident #4.
-The bubble on the medication card contained 1 tablet of Toviaz ER 4mg with 29 doses left to be administered.
-There was a bottle from a second pharmacy with a label dated 10/21/18, for Toviaz 8mg of 90 tablets with 87 doses remaining in the bottle.

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Interview with a first shift medication aide (MA) on 12/19/18 at 9:00am revealed:
-She worked first shift and administered Resident #4's morning medications.
-She administered Toviaz 8mg the past 3 mornings at 08:00am.
-She administered Toviaz 8mg out of the bottle not the bubble pack.
-She did not compare the label on each medication to the eMAR correctly to make sure they matched before administering medication.
-The Toviaz label for 8mg every day did not match the eMAR order for Toviaz 4mg every day.
-The correct order was for Toviaz 8mg every day.
-The MAs were responsible for completing a 24 hour report daily that was used to communicate medication changes to the MA for the next shift.
-She did not know why only 3 Toviaz 8mg tablets were used out of 90 since 10/21/18.

Interview with Resident #4 on 12/19/18 at 11:08am revealed:
-He did not know if he was taking a medication for his bladder.
-He "goes" to the bathroom a lot to urinate.
-He used a "lot" of adult incontinent briefs every day.

Interview with the Resident Care Coordinator (RCC) on 12/19/18 at 11:10am revealed:
-The medication aides (MA) were responsible for receiving new orders from the physician and faxing those orders to the pharmacy.
-The MAs were responsible for order entry into the eMAR.
-She was responsible for making sure the MAs had entered all new medication orders into the eMAR correctly.
-The MA transcribed the order incorrectly by mistaking the 8mg for 4mg and she missed it as

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well.
-The MAs were responsible for making sure the pharmacy dispensed the correct medication to the facility.
-The MAs were responsible for making sure the label on the medication matched the entry on the eMAR.
-She or the MAs were responsible for getting clarification from the provider if a discrepancy was identified.
-She was responsible for making sure the new order tracking form was filled out by the MAs.
-She could not provide a copy of the new order tracking form for Resident #4 and could not verify it was completed.
-The new order tracking form was to be completed on all residents with new orders.
-She along with the Health and Wellness Director (HWD) were responsible for monthly cart audits on random residents.
-A cart audit entailed selecting 3 residents and comparing the orders, the medication on hand and the eMARs for accuracy and the medication were in the cart.
-There were no audits completed on the eMARs to check for holes, accuracy, or refusals and missing medications.

Interview with the HWD on 12/19/18 at 11:25am revealed:
-She did not know Resident #4 was not receiving the Toviaz 8mg.
-The MAs were responsible for inputting all new medication orders into the eMAR and faxing the order to the pharmacy.
-The MAs would fill out a new order tracking form and put the form in the RCC's box to review.
-She entered all new FL2 orders into the eMAR.
-The MAs were responsible for checking the

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eMAR orders behind her on all new residents to the facility.
-The MAs were responsible for checking all medication bottles brought from home with the order before administering the medication.
-Resident #4 brought a bottle of Toviaz 8mg with him to the facility and there was not a count done on the amount of tablets in the bottle.
-She was not able to provide a copy of the new order tracking sheet for Resident #4.

Telephone interview with Resident #4's physician on 12/19/18 at 12:07pm revealed:
-Resident #4 received the Toviaz for an overactive bladder.
-He did not know Resident #4 was not taking the Toviaz as ordered.
-There was no documentation in Resident #4's record about clarification of the order.
-An order was written for Toviaz ER 8mg every day on 09/28/18 and 10/18/18.
-He expected the facility to give the Toviaz as ordered because it could cause increased frequency of urination if the correct dose was not administered.

Telephone interview with Resident #4's family member on 12/19/18 at 12:27pm revealed:
-She brought a bottle of Toviaz 8mg dated 07/26/18 containing 90 tablets to the facility on 10/05/18.
-Resident #4 received all of his medications from a pharmacy that the facility did not use.
-Resident #4 took the Toviaz for his urinary frequency.
-She did not know Resident #4 had not received the Toviaz as prescribed by the physician.

Telephone interview with a representative from Resident #4's backup pharmacy on 12/19/18 at

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D 358	Continued From page 18 12:29pm revealed a onetime bubble pack with 30 tablets for Toviaz 4mg was dispensed on 10/05/18 according to the order that was entered by the MA. Telephone interview with a regenerative from Resident #4's pharmacy on 12/19/18 at 12:38pm revealed: -On 07/26/18 Toviaz 8mg with 90 tablets was dispensed to Resident #4's family member. -On 10/22/18 Toviaz 8mg with 90 tablets was dispensed to Resident #4's family member. Interview with the Administrator on 12/19/18 at 1:00pm revealed: -Residents should be receiving medications based on physician's orders. -The MAs were responsible for comparing the medication label to the eMAR before they administered medication to a resident. -The RCC and HWD were responsible for reviewing all medication orders and the eMAR to make sure orders were entered correctly according to the completed new order tracking sheet that was to be completed after receiving the new order. -She was not able to confirm the new order tracking sheet was completed on Resident #4's orders. -The MAs were responsible for entering new medication orders into the eMAR and filling out a new order tracking form for the RCC or HWD to review. -The RCC and HWD were responsible for completing monthly random record audits to compare the eMARs to the medication in the medication cart and compare the eMARs to new medication orders. -The MAs, RCC, or HWD were responsible for clarifying orders and correcting any eMAR	D 358		

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entries.
-The MAs were responsible for medication administration to the residents.
-The MA entered the incorrect dose into the eMAR and was missed by the RCC and HWD.
-The correct order for Toviaz 8mg was delivered by Resident #4's family member because that pharmacy was the only pharmacy Resident #4 used, not the facility pharmacy.

3. Review of Resident #5's current FL2 dated 01/29/18 revealed:
-Diagnoses included coronary artery disease, hypertension, and hyperlipidemia.
-There was a physician's order for fluticasone (a medication used for allergies) 50mcg, 1 spray per nostril twice per day.

Review of Resident #5's physician order dated 06/11/18 revealed "d/c [discontinue] fluticasone nasal spray 50mcg".

Review of a subsequent physicians order for Resident #5 dated 07/16/18 revealed "start Flonase 50mcg instill 1 spray in each nostril daily".

Review of Resident #5's July 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Flonase Suspension 50 MCG/ACT (fluticasone proplonate) 1 spray in both nostrils one time a day for allergies had been administered.
-There was a start date of 07/17/18 at 8:00am.
-There was a discontinue date of 08/14/18 at 11:24pm.

Review of Resident #5's August 2018 eMAR revealed:

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D 358	Continued From page 20 -There was an entry for Flonase Suspension 50 MCG/ACT (fluticasone proplonate) 1 spray in both nostrils one time a day for allergies had been administered. -There was a start date of 07/17/18 at 8:00am. -There was a discontinue date of 08/14/18 at 11:24pm. Review of Resident #5's September, October, November, and December 2018 eMAR revealed there was no entry for Flonase Suspension 50 MCG/ACT (fluticasone proplonate) 1 spray in both nostrils one time a day for allergies. Interview with the Health and Wellness Director on 12/19/18 at 9:40am revealed: -She could not find any discontinue order for the Flonase. -She did not know why the Flonase had been discontinued. Interview with a medication aide on 12/19/18 at 10:15am revealed: -She administered Resident #5's medications. -She did not recall Resident #5 being administered Flonase nasal spray. Interview with Resident #5's Primary Provider on 12/19/18 at 1:30pm revealed: -Her records showed that Resident #5 should still be on the Flonase for her allergies. -She did not have any concerns that Resident #5 had not received the medication. -No harm would have occurred with her not getting the Flonase. Telephone interview with a representative from the contracted pharmacy on 12/19/18 at 10:49am revealed: -Resident #5 still had an active order for Flonase	D 358		

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D 358	Continued From page 21 with the pharmacy. -The Flonase had been dispensed last on 07/21/18. -The facility had not requested any additional refills. Interview with the Administrator on 12/19/18 at 1:45pm revealed she did not know why the medication had been discontinued on the MAR. Resident #5 was currently on a leave of absence from the facility and her medications were not available for review.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure electronic Medication Administration Records (eMARs) were accurate for 2 of 5 sampled residents (Resident #1 and #5).

1. Review of Resident #1's current FL2 dated 11/21/18 revealed:
-Diagnoses included diabetes, congestive heart failure, and hypothyroidism.
-There was a physician's order for vitamin D 1,000 IU take 1 tablet daily (supplement used to treat vitamin D deficiency).

Review of Resident #1's physician's order dated 07/28/18 revealed a physician's order for vitamin D 800 IU take 1 tablet daily.

Review of Resident #1's physician's order dated 11/08/18 revealed a clarification order signed by Resident #1's primary care physician (PCP) to discontinue vitamin D 800 IU and continue vitamin D 1,000 IU take 1 tablet daily.

Review of Resident #1's November 2018 electronic Medication Administration Record (eMAR) revealed:
-There was a computer generated entry for vitamin D 1,000 IU take 1 tablet daily scheduled to be administered at 9:00am.
-Vitamin D 1,000 IU was documented as administered from 11/01/18 to 11/30/18.
-There was a computer generated entry for

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vitamin D 400 IU take 2 tablets (800 IU) daily scheduled to be administered at 8:00am.
-Vitamin D 400 IU was documented as administered from 11/01/18 to 11/09/18.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/19/18 at 10:49am revealed the pharmacy was not able to view orders the facility was entering into their eMAR.

Interview with a second shift medication aide (MA) on 12/18/19 at 3:17pm revealed:
-She did not know Resident #1's physician order for 400 IU had been discontinued and he had been continued on vitamin D 1,000 IU.
-She did not know there were two orders for vitamin D on the eMAR.
-There was only vitamin D 400 IU available to be administered to Resident #1.
-The MAs were responsible for entering new physician orders into the eMAR.

Interview with a first shift MA on 12/19/18 at 8:19am revealed:
-She did not notice there were two orders for vitamin D on the eMAR.
-The MAs were responsible for entering new physician orders into the eMAR.
-She was responsible for comparing the label on each medication to the eMAR to make sure they matched before administering medication.
-She, other MAs, the Resident Care Coordinator (RCC), and the Health and Wellness Director (HWD) had access to change order entries on the eMAR that were incorrect.

Interview with the RCC on 12/19/18 at 12:46pm revealed:
-She did not know Resident #1 was receiving the

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incorrect vitamin D dose.
-The MAs were responsible for order entry into the eMAR software.
-She was responsible for making sure the MAs had entered all new medication orders into the eMAR correctly.
-She was not sure why the error had not been discovered and corrected.
-The MAs were responsible for making sure the label on the medication matched the entry on the eMAR.

Interview with the HWD on 12/18/18 at 3:49pm and on 12/19/18 at 8:15am revealed:
-She did not know Resident #1 was receiving the incorrect vitamin D dose.
-She did not know Resident #1's vitamin D dose had been changed.
-The MAs were responsible for entering all new medication orders into the eMAR and faxing the order to the pharmacy.
-The MAs would fill out a new order tracking form and put the form in the RCC's box to review.

Interview with the Administrator on 12/19/18 at 1:10pm revealed:
-There should be 2 facility staff (MA, RCC, or HWD) reviewing all medication orders and the eMAR to make sure orders were entered correctly.
-The MAs were responsible for inputting new medication orders on the eMAR and filling out a new order tracking form for the RCC or HWD to review.
-The RCC and HWD were responsible for completing monthly random record audits that included comparing the eMARs to the medication in the medication cart and comparing the eMARs to new medication orders.
-She did not know why the error was not caught

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D 367	Continued From page 25 during the audit process. 2. Review of Resident #4's current FL2 dated 09/28/18 revealed: -Diagnoses included dementia, urinary tract infections and atrial fibrillation. -An order for Toviaz ER (a medication used to treat and over active bladder) 8mg every day. -Resident #4 was incontinent of bowel and bladder. Review of Resident #4's physician's order dated 10/18/18 revealed a subsequence physician's order for Toviaz 8mg every day. Review of Resident #4's October 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for Toviaz 4mg every day scheduled to be administered at 10:00am. -Toviaz 4mg ER was documented as administered from 10/06/18 to 10/31/18 at 10:00am. -Resident #4 was out of the facility on 10/01/18 - 10/05/18. -There was no entry for Toviaz 8mg every day. Review of Resident #4's November 2018 eMAR revealed: -There was a computer generated entry for Toviaz 4mg every day scheduled to be administered at 10:00am. -Toviaz 4mg ER was documented as administered from 11/01/18 to 11/16/18 at 10:00am. -Toviaz 4mg ER was documented as administered from 11/16/18 to 11/30/18 at 10:00am. -There was no entry for Toviaz 8mg every day.	D 367		

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Review of Resident #4's December 2018 eMAR revealed:
-There was a computer generated entry for Toviaz 4mg every day scheduled to be administered at 08:00am.
-Toviaz 4mg ER was documented as administered from 12/01/18 to 11/19/18 at 08:00am.
-There was no entry for Toviaz 8mg every day.

Interview with a first shift medication aide (MA) on 12/19/18 at 9:00am revealed:
-The Toviaz label for 8mg every day did not match the eMAR order for Toviaz 4mg every day.
-The correct order was for Toviaz 8mg every day.
-The MAs were responsible for entering the new orders into the eMAR.
-The Redicent Care Coordinator (RCC) and the Health and Wellness Director (HWD) were responsible for checking the entries in the eMAR with the orders for accuarcy.

Interview with the Resident Care Coordinator (RCC) on 12/19/18 at 11:10am revealed:
-She did not know the Toviaz 8mg dose from the bottle did not match the Toviaz 4mg dose documented as administered on the eMAR.
-The MAs were responsible for order entry into the eMAR.
-She was responsible for making sure the MAs had entered all new medication orders into the eMAR correctly.
-The MAs were responsible for making sure the pharmacy dispensed the correct medication to the facility.
-The MAs were responsible for making sure the label on the medication matched the entry on the eMAR.

Interview with the HWD on 12/19/18 at 11:25am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036015	A. BUILDING: _____ B. WING _____	12/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ROBINWOOD	1750 ROBINWOOD ROAD GASTONIA, NC 28054

(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 367	Continued From page 27 revealed: -She did not know the Toviaz 8mg from the bottle did not match the Toviaz 4mg documented as administered on the eMAR. -The MAs were responsible for documenting exactly what the administered. -The MAs were responsible for the label on the medication matched the entry on the eMAR. Telephone interview with Resident #4's physician on 12/19/18 at 12:07pm revealed an order was written for Toviaz ER 8mg every day on 09/28/18 and 10/18/18. Interview with the Administrator on 12/19/18 at 1:00pm revealed: -The MA entered the incorrect dose into the eMAR and was missed by the RCC and HWD. -The correct order for Toviaz 8mg was delivered by Resident #4's family member because that pharmacy was the only pharmacy Resident #4 used, not the facility pharmacy. -The MAs were responsible for comparing the medication label to the eMAR before they administered medication to a resident. -The MAs were responsible for medication administration to the residents and the documentation of the medication administered in the eMAR.	D 367		