



PRINTED: 04/24/2019
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL016006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/11/2019	
NAME OF PROVIDER OR SUPPLIER BROOKDALE MOREHEAD CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 107 BRYAN STREET MOREHEAD CITY, NC 28557		
(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 Carteret County Department of Social Services conducted an annual survey on April 9-11, 2019.	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: Based on interviews and record reviews, the facility failed to administer medications as ordered for 1 of 6 sampled residents (#2) including errors with medications used for pain, to thin mucus, to thin the blood, a vitamin supplement and a laxative. The finding are: Review of Resident #2's current FL-2 dated 03/20/19 revealed diagnoses included pneumonia, acute hypoxic respiratory failure,	D 358		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

WTTF11

(X6) DATE

04/30/2019

If continuation sheet 1 of 12

Reviewed and accepted. HF

May 3, 2019

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D 358	Continued From page 1 pleural effusion, congestive heart failure, chronic obstructive pulmonary disease, hypothyroidism, generalized weakness, chronic lymphocytic lymphoma and chronic kidney disease stage 5. Review of Resident #2's previous FL-2 dated 02/01/19 revealed diagnoses included fracture of the left femur, chronic obstructive pulmonary disease, chronic lymphocytic leukemia, anemia, hypothyroidism, muscle weakness, dysphagia and abnormal gait. Review of Resident #2's Resident Register revealed an admission date of 02/05/19. a. Review of Resident #2's previous FL-2 dated 02/01/19 revealed an order for Aspirin Enteric Coated (EC) 81mg daily. (Aspirin EC is used as a blood thinner.) Review of Resident #2's February 2019 electronic medication record (eMAR) revealed: -There was a computer generated entry for Aspirin EC 81 mg take one tablet daily with a scheduled administration time of 8:00am. -There was a charting code for "Other/See Nurse Notes" documented for Aspirin 81mg on 02/06/19, 02/07/19, 02/09/19, and 02/11/19 at 8:00am. -There was documentation of a charting code as "Hospitalized" on 02/08/19. Review of Resident #2's electronic progress notes revealed: -There was an entry for Aspirin EC 81mg one tablet daily on 02/06/19 at 9:58am, 02/07/19 at 10:31am, 02/09/19 at 8:42am and 02/11/19 at 10:17am -There was no documentation regarding missed doses of Aspirin EC 81mg or the medication	D 358		

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D 358	Continued From page 2 being unavailable. Review of Resident #2's dispensing records from the facility's contracted pharmacy revealed there were 23 tablets of Aspirin EC 81mg dispensed on 02/12/19. Attempted telephone interview with Resident #2's primary care provider on 04/11/19 at 2:06pm. Refer to the interview with Resident #2 on 04/11/19 at 7:55am. Refer to the interview with a medication aide (MA) on 04/11/19 at 10:55am. Refer to the telephone interview with a pharmacist with the facility's contracted pharmacy provider on 04/11/19 at 12:48pm. Refer to the interview with the lead medication aide (MA) on 04/11/19 at 3:00pm and at 4:00pm. Refer to the interview with the Executive Director on 04/11/19 at 4:45pm. b. Review of Resident #2's previous FL-2 dated 02/01/19 revealed an order for Acetaminophen 500mg one tablet three times daily. (Acetaminophen is a medication used for pain.) Review of Resident #2's February 2019 electronic medication record (eMAR) revealed: -There was a computer generated entry for Acetaminophen 500mg one tablet three times daily with a scheduled administration time of 8:00am, 12:00pm and 4:00pm. -There was a charting code for "Other/See Nurse Notes" documented for Acetaminophen 500mg on 02/05/19 at 4:00pm, 02/06/19 at 8:00am,	D 358			

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D 358	Continued From page 3 12:00pm and 4:00pm, 02/08/19 at 4:00pm, 02/09/19 at 8:00am and 12:00pm and 02/11/19 at 4:00pm. -There was documentation of a charting code as "Hospitalized" on 02/07/19 at 12:00pm and 4:00pm and on 02/08/19 at 8:00am and 12:00pm. Review of Resident #2's electronic progress notes revealed: -There was entry for Acetaminophen 500mg one capsule three times daily on 02/06/19 at 9:59am and 1:42pm, 02/09/19 at 8:59am and 11:50am. -On 02/11/19 at 9:03pm, there was an entry Resident #2 was missing the scheduled Acetaminophen 500mg and contact would be made with the contracted pharmacy provider. -There was documentation Acetaminophen 500 mg was not administered on 02/05/19 at 7:04pm, 02/06/19 at 4:49pm, 02/08/19 at 4:45pm and 02/11/19 at 4:21pm with a reason as awaiting pharmacy. Review of Resident #2's dispensing records from the facility's contracted pharmacy revealed there were 69 tablets of Acetaminophen 500mg was dispensed on 02/12/19. Attempted telephone interview with Resident #2's primary care provider on 04/11/19 at 2:06pm. Refer to the interview with Resident #2 on 04/11/19 at 7:55am. Refer to the interview with a medication aide (MA) on 04/11/19 at 10:55am. Refer to the telephone interview with a pharmacist with the facility's contracted pharmacy provider on 04/11/19 at 12:48pm.	D 358			

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D 358	Continued From page 4 Refer to the interview with the lead medication aide (MA) on 04/11/19 at 3:00pm and at 4:00pm. Refer to the interview with the Executive Director on 04/11/19 at 4:45pm. c. Review of Resident #2's previous FL-2 dated 02/01/19 revealed an order for Mucinex extended release (ER) 600mg one tablet twice daily. (Mucinex is a medication used to thin liquids in the respiratory system.) Review of Resident #2's February 2019 electronic medication record (eMAR) revealed: -There was a computer generated entry for Mucinex ER 600mg one tablet twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was a charting code for "Other/See Nurse Notes" documented for Mucinex ER on 02/05/19 at 8:00pm, 02/06/19 at 8:00am and 8:00pm, 02/07/19 at 8:00am and 02/08/19 from 8:00pm through 02/11/19 at 8:00pm. -There was a charting code for Mucinex ER 600mg documented as "Hospitalized" on 02/07/19 at 8:00pm and 02/08/19 at 8:00am. Review of Resident #2's electronic progress notes revealed: -There was documentation Mucinex ER 600mg was not administered on 02/05/19 at 7:05pm, 02/06/19 at 7:22pm and 02/08/19 at 10:30pm with a reason as awaiting pharmacy. -There was an entry for Mucinex ER 600mg one tablet twice daily on 02/06/19 at 10:02am, 02/07/19 at 10:52am, 02/09/19 at 8:58am, 02/09/19 at 8:19pm, 02/10/19 at 1:43pm, 02/10/19 at 7:14pm and 02/11/19 at 10:18am and 10:03pm. -On 02/11/19 at 9:03pm, there was an entry	D 358		

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D 358	Continued From page 5 Resident #2 was missing the scheduled Mucinex ER 600mg and contact would be made with the contracted pharmacy provider. Review of Resident #2's dispensing records from the facility's contracted pharmacy revealed there were 46 tablets of Mucinex ER 600mg tablets dispensed on 02/12/19. Attempted telephone interview with Resident #2's primary care provider on 04/11/19 at 2:06pm. Refer to the interview with Resident #2 on 04/11/19 at 7:55am. Refer to the interview with a medication aide (MA) on 04/11/19 at 10:55am. Refer to the telephone interview with a pharmacist with the facility's contracted pharmacy provider on 04/11/19 at 12:48pm. Refer to the interview with the lead medication aide (MA) on 04/11/19 at 3:00pm and at 4:00pm. Refer to the interview with the Executive Director on 04/11/19 at 4:45pm. d. Review of Resident #2's previous FL-2 dated 02/01/19 revealed an order for Vitamin D3 1000units one tablet daily. (Vitamin D3 is a vitamin supplement.) Review of Resident #2's February 2019 electronic medication record (eMAR) revealed: -There was a computer generated entry for Vitamin D3 1000units one tablet daily with a scheduled administration time of 8:00am. -There was a charting code for "Other/See Nurse Notes" documented for Vitamin D3 on 02/06/19,	D 358		

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D 358	Continued From page 6 02/07/19, 02/09/19 - 02/11/19 at 8:00am. -There was a charting code for Vitamin D3 documented as "Hospitalized" on 02/08/19 at 8:00am. Review of Resident #2's electronic progress notes revealed: -There was an entry for Vitamin D3 1000units one tablet daily on 02/06/19 at 10:02am, 02/07/19 at 10:31am, 02/09/19 at 8:58am, 02/10/19 at 1:43pm and 02/11/19 at 10:18am. -There was no documentation regarding missed doses of Vitamin D3 1000 units or the medication being unavailable. Review of Resident #2's dispensing records from the facility's contracted pharmacy revealed there were 23 tablets of Vitamin D3 1000unit tablets dispensed on 02/12/19. Attempted telephone interview with Resident #2's primary care provider on 04/11/19 at 2:06pm. Refer to the interview with Resident #2 on 04/11/19 at 7:55am. Refer to the interview with a medication aide (MA) on 04/11/19 at 10:55am. Refer to the telephone interview with a pharmacist with the facility's contracted pharmacy provider on 04/11/19 at 12:48pm. Refer to the interview with the lead medication aide (MA) on 04/11/19 at 3:00pm and 4:00pm. Refer to the interview with the Executive Director on 04/11/19 at 4:45pm. e. Review of Resident #2's previous FL-2 dated	D 358		

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D 358	Continued From page 7 02/01/19 revealed an order for Senexon-S two tablets twice daily. (Senexon-S is a medication used as a laxative for constipation.) Review of Resident #2's February 2019 electronic medication record (eMAR) revealed: -There was a computer generated entry for Senexon-S 8.6-50mcg two tablets twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was a charting code for "Other/See Nurse Notes" documented for Senexon-S on 02/05/19 at 8:00pm 02/06/19 at 8:00am and 8:00pm, 02/07/19 at 8:00am and from 8:00 pm on 02/08/19 - 02/11/19 at 8:00pm. -There was a charting code for Senexon-S documented as "Hospitalized" on 02/07/19 at 8:00pm and 02/08/19 at 8:00am. Review of Resident #2's electronic progress notes revealed: -There was documentation Senexon-S was not administered on 02/05/19 at 7:05pm, 02/06/19 at 7:23pm, 02/08/19 at 10:30pm and 02/11/19 at 9:02pm with a reason as awaiting pharmacy. -There was an entry for Senexon-S 8.6-50mg 2 tablets twice daily on 02/06/19 at 10:03am, 02/07/19 at 10:30am, 02/09/19 at 8:58am and 8:19pm, 02/10/19 at 1:43pm and 02/11/19 at 10:18am. -On 02/11/19 at 9:03pm, there was an entry Resident #2 was missing Senexon-S 8.6-50mg and contact would be made with the contracted pharmacy provider. Review of Resident #2's dispensing records from the facility's contracted pharmacy revealed there were 46 tablets of Senexon-S 8.6-50mg dispensed on 02/12/19.	D 358		

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D 358	Continued From page 8 Attempted telephone interview with Resident #2's primary care provider on 04/11/19 at 2:06pm. Refer to the interview with Resident #2 on 04/11/19 at 7:55am. Refer to the interview with a medication aide (MA) on 04/11/19 at 10:55am. Refer to the telephone interview with a pharmacist with the facility's contracted pharmacy provider on 04/11/19 at 12:48pm. Refer to the interview with the lead medication aide (MA) on 04/11/19 at 3:00pm and at 4:00pm. Refer to the interview with the Executive Director on 04/11/19 at 4:45pm. f. Review of Resident #2's previous FL-2 dated 02/01/19 revealed an order for Celebrex 100mg one tablet daily. (Celebrex is a medication used for pain.) Review of Resident #2's February 2019 electronic medication record (eMAR) revealed: -There was a computer generated entry Celebrex 100mg take one capsule once daily with a scheduled administration time of 8:00am. -There was a charting code for "Other/See Nurse Notes" documented for Celebrex 100mg on 02/11/19 at 8:00am. Review of Resident #2's electronic progress notes revealed: -There was an entry for Celebrex 100mg one capsule daily on 02/11/19 at 10:17am. -There was no documentation regarding missed doses of Celebrex 100mg or the medication being unavailable.	D 358		

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D 358	Continued From page 9 Review of Resident #2's dispensing records from the facility's contracted pharmacy revealed there were 23 tablets of Celebrex 100mg dispensed on 02/12/19. Attempted telephone interview with Resident #2's primary care provider on 04/11/19 at 2:06pm. Refer to the interview with Resident #2 on 04/11/19 at 7:55am. Refer to the interview with a medication aide (MA) on 04/11/19 at 10:55am. Refer to the telephone interview with a pharmacist with the facility's contracted pharmacy provider on 04/11/19 at 12:48pm. Refer to the interview with the lead medication aide (MA) on 04/11/19 at 3:00pm and at 4:00pm. Refer to the interview with the Executive Director on 04/11/19 at 4:45pm. Interview with Resident #2 on 04/11/19 at 7:55am revealed she was not aware of missing any medication since she was admitted to the facility in February 2019. Interview with a medication aide (MA) on 04/11/19 at 10:55am revealed: -Resident #2 had some of her own medications when she was admitted to the facility in February 2019, but not all of them. -The MAs ordered medication refills using the stickers from the medication labels and put them on a form and faxed them to the pharmacy for refills. -The contracted pharmacy usually delivered	D 358		

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D 358	Continued From page 10 medications to the facility during third shift. -Resident #2's medications were not available in the facility when the MAs documented the reason as awaiting pharmacy in the electronic progress notes. -Some of the entries that documented the scheduled medications in Resident #2's progress notes on 02/16/19 during day shift were entered by her. -She did not always put a reason why medications were not given in the progress notes and only entered the name, dose and frequency of the medication along with date and time the medication was supposed to be given. -She was not sure why some of Resident #2's medications were not available from 02/05/19 through 02/11/19. Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 04/11/19 at 12:48pm revealed: -An initial fax was received from the facility for Resident #2's medications to be filled on 02/11/19 at 3:43am. -There was a second fax from the facility on 02/11/19 at 9:23 p.m. that the resident had missed certain medications. -Resident #2's medications were initially delivered to the facility from the contracted pharmacy on 02/12/19 at 2:00am. Interview with the lead MA on 04/11/19 at 3:00pm and at 4:00pm revealed: -She did medication cart audits every other week which included checking the medications on hand with the electronic medication records (eMARS) comparing them to the primary care provider's (PCP's) orders. -Third shift MAs completed a medication cart audit at least monthly which consisted of assuring	D 358		

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D 358	Continued From page 11 the medication carts were locked, the eMARS hidden, and assuring medications were stored separately. -When residents were admitted to the facility, sometimes the resident came with medication and sometimes the residents would have no medications. -Resident #2 was admitted from a local rehabilitation center without any medication. -The only medications Resident #2 had on admission came from her home. -The facility had a back-up pharmacy but over the counter medications could not be provided from the back-up pharmacy. -She did not know who would be responsible to make sure a resident being admitted to the facility had their ordered medications because "they" don't know what medications they would have until the resident got there. -Medications were not ordered until a resident was admitted to the facility. -She was not sure why it took until 02/12/19 for all Resident #2's medications to be available. Interview with the Executive Director on 04/11/19 at 4:45pm revealed: -She would have expected for Resident #2's medications to be clarified or have received an order to place the medications not available on hold for Resident #2 when the resident arrived on admission. -On admission, the MAs would be responsible to fax medication orders to the contracted pharmacy provider when the resident was admitted, then follow up would be done by the Health and Wellness Coordinator or the Health and Wellness Director.	D 358		

13F.1004(a) Medication Administration – Standard Deficiency

1. The community will utilize the New Tracking Order Form for new orders.
2. The Medication Aides (MA), will enter into the Point Click Care eMAR and implement the new medication order, verify the pharmacy has received the order and then place a **copy** of the new order along with the New Order Tracking Form into the clinical box for review.
3. The original order will be initialed and dated and placed in the resident record.
4. The Health and Wellness Director (HWD), Resident Care Coordinator (RCC) or designee will check for medication orders twice per day to verify completion and accuracy of the transcribed order and to verify that the medication is available from the pharmacy or from the back up pharmacy.
5. The RCC or designee will audit the eMAR on a daily basis to verify medications are documented as administered and codes are entered for those that are not administered.
6. The date of correction for this standard deficiency is May 23, 2019.

Elizabeth Springle, ED

13F.1004(a) Medication Administration – Standard Deficiency

1. The community audited the medication carts for presence of prescribed medications for current residents during and immediately following the survey. There were no missing medications.
2. The community will utilize the New Tracking Order Form for new orders.
3. The Medication Aides (MA), will enter into the Point Click Care eMAR and implement the new medication order, verify the pharmacy has received the order and then place a **copy** of the new order along with the New Order Tracking Form into the clinical box for review.
4. The original order will be initialed and dated and placed in the resident record.
5. The Health and Wellness Director (HWD), Resident Care Coordinator (RCC) or designee will check for medication orders twice per day to verify completion and accuracy of the transcribed order and to verify that the medication is available from the pharmacy or from the back up pharmacy.
6. The RCC or designee will audit the eMAR on a daily basis to verify medications are documented as administered and codes are entered for those that are not administered.
7. Medication carts are audited weekly by the RCC (Resident Care Coordinator) or designee. The HWD or designee will review the audits on a weekly basis to ensure compliance.
8. The date of correction for this standard deficiency is May 23, 2019.

Elizabeth Springle, ED

Forte, Hope

From: Elizabeth Springle <espringle@brookdale.com>
Sent: Tuesday, April 30, 2019 9:45 AM
To: Forte, Hope
Cc: Amy Costin; Virginia Steinman
Subject: [External] Plan for Correction
Attachments: POC for State 2019.pdf

CAUTION: External email. Do not click links or open attachments unless you verify. Send all suspicious email as an attachment to report.spam@nc.gov

Hope,
Please find the plan of correction for our statement of deficiency. If you need anything please let me know.

Thank you,

Elizabeth Annette Springle

Executive Director
Brookdale Morehead City (BU 18260)
107 Bryan St.
Morehead City, NC 28557
Community 252-726-4454
Cell 252-269-9712



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Forte, Hope

From: Elizabeth Springle <espringle@brookdale.com>
Sent: Friday, May 03, 2019 3:12 PM
To: Forte, Hope
Cc: Amy Costin; Survey Management
Subject: [External] Plan of Correction

CAUTION: External email. Do not click links or open attachments unless you verify. Send all suspicious email as an attachment to report.spam@nc.gov

Hope,

Per our conversation today our plan of correction has been updated with what we spoke about earlier. Instead of doing an addendum it has been added to the POC. If you need anything else please let me know.

Thank you,

Annette Springle

Executive Director
Brookdale Morehead City (BU 18260)
107 Bryan St.
Morehead City, NC 28557
Community 252-726-4454
Cell 252-269-9712



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