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
	HAL060019	A. BUILDING: _____ B. WING _____	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF CHARLOTTE	6000 PARK SOUTH DRIVE CHARLOTTE, NC 28210

(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 Mecklenburg County Department of Social Services conducted an annual survey on 07/17/19-07/19/19.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure physician's orders were implemented for 1 of 7 sampled residents (Resident #1) related to continuous oxygen. Review of Resident #1's current FL-2, dated 06/05/19 revealed: -Diagnoses included restrictive thoracic disorder due to morbid obesity, chronic hypercapnic respiratory failure, and acute on chronic diastolic heart failure. -There was a physician's order for continuous	D 276		

Reviewed and accepted by CD on 09/24/19

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D 276	Continued From page 1 oxygen (O2) at 3 liters (L). Review of hospital clinical summary discharge information, dated 06/05/19, revealed the "patient summary" section of the document revealed Resident #1's diagnoses included "chronic hypoxic respiratory failure on 3L home O2." Review of Resident #1's current signed physician's orders, dated 06/17/19, revealed an order for oxygen at 3L per minute, continuous. Review of Resident #1's most recent care plan, dated 10/07/18 revealed no information regarding physician's orders related to oxygen therapy. Review of Resident #1's most recent licensed health professional support task list, dated 05/01/19 revealed: -Resident #1 had "oxygen administration and monitoring" listed as a task. -"He has oxygen available at 2 LPM (liters per minute)/NC PRN (nasal cannula as needed) and it is set at the correct dose. He denies need for O2 and lungs are clear to auscultation." Review of Resident #1's progress notes revealed: -On 05/14/19, there was documentation Resident #1, "Returned from MD/Pulmonology appointment ...new order noted for Lasix for 7 days for pulmonary edema, O2 @ 3 LPM continuously." -On 05/15/19, there was documentation "Lasix in progress as ordered, respirations unlabored on continuous O2 at 3 LPM." -On 05/16/19, there was documentation "Lasix continues as ordered by MD. Respirations regular, non-labored on cont O2 @ 3 LPM." -On 06/05/19, a "Move In/Return Note" documented: "Respirations unlabored on	D 276		

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D 276	Continued From page 2 continuous O2 @ 3 LPM." -On 06/08/19, there was documentation, "Respirations unlabored on continuous O2, no signs of congestion or cough." -Other entries which documented that Resident #1 was on continuous O2 at 3 LPM were dated 06/06/19, 06/07/19 and 06/11/19. Review of Resident #1's electronic medication administration records (eMARs) for May, June, and July 2019 revealed there were no entries on the eMARs for continuous oxygen at 3 LPM. Observation of Resident #1 on 07/17/19 at 10:25am revealed: -Resident #1 was observed in the elevator with a family member on their way to a medical appointment. -Resident #1 was not wearing oxygen. Observation of Resident #1 on 07/18/19 at 10:55am revealed: -Resident #1 was in the hallway, exiting his room in his wheelchair, on his way down to the dining room for lunch. -Resident #1 was not wearing an oxygen cannula and had no portable oxygen tank on his wheelchair. Interview with Resident #1 on 7/18/19 at 10:55am revealed: -He had no portable oxygen tank on his chair. -When staff helped him down to the dining room for lunch, they would sometimes ask if he wanted to take an oxygen tank with him, but he would always decline this offer because "he did okay without it" and "didn't have to wear it all the time." -He always wore oxygen when he was sleeping at night, at 3 L, and would "sometimes" put it on during the day when he felt like he needed it.	D 276		

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D 276	Continued From page 3 Interview with a medication aide (MA) on 07/18/19 at 11:40am revealed: -She thought Resident #1's order for oxygen was only "as needed." -She was not aware that he had an order for continuous oxygen at 3 L. -Oxygen orders did not populate on the eMAR, to be signed off daily by the MA, for any residents who used oxygen. -Prior to the facility switching to the eMAR system "a year or so ago" oxygen orders populated on the paper MARs, and the MAs had to sign off daily that oxygen was being administered as ordered. -The MAs relied on the nursing staff to inform them of any changes related to residents' oxygen orders. Interview with the Assisted Living Coordinator on 07/18/19 at 3:26pm revealed: -She thought Resident #1's order for oxygen therapy was only "as needed." -Resident #1 usually wore his nasal cannula when he was in his room, but would not take any portable oxygen tanks with him when he left his room. Interview with the Resident Care Director (RCD) on 07/18/19 at 11:50am revealed: -She thought Resident #1's order for oxygen therapy was only "as needed." -Resident #1 usually wore his oxygen "most of the time." -She had observed Resident #1 downstairs in the dining area wearing his oxygen nasal cannula in the past. -She did not think the facility had ever communicated with Resident #1's physician regarding him not wearing his oxygen all the time	D 276		

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D 276	Continued From page 4 because staff were under the impression that his order was to wear it "as needed." -Oxygen therapy orders were not listed on the eMAR for Resident #1 or any resident that had an order for oxygen. -It was facility policy that documentation of oxygen administration was not required. -An order for oxygen therapy populated on a different screen in the eMAR system, the "order summary" section. -The order summary screen was not routinely viewed by MA staff, unless they specifically went to that screen for a resident. -The order summary screen required no routine action, such as "signing off" that a medication or treatment had been administered on a regular basis. Interview with a personal care aide (PCA) on 07/19/19 at 9:10am revealed: -She provided care to Resident #1 on a regular basis. -She thought Resident #1 only had an order to wear oxygen "as needed." -Resident #1 usually did "okay" when not wearing oxygen, unless he was exerting himself, such as during physical therapy, or when he was wheeling his wheelchair without assistance from staff. -Resident #1 would tell staff when he felt like he needed his oxygen. -She relied on the nursing staff and the MAs to inform her when a resident had a change to a treatment order, such as oxygen. Interview with Resident #1's physical therapy assistant on 07/19/19 at 9:20am revealed: -She had been working with Resident #1 for a while. -Resident #1 "usually" wore his oxygen during therapy sessions because he sometimes was	D 276		

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D 276	Continued From page 5 short of breath. -She monitored the resident's oxygen saturations during therapy sessions. Interview with the RCD on 07/19/19 at 9:30am revealed: -She had spoken with the facility's corporate nurse and confirmed that the only places oxygen therapy were expected to be documented would be on a resident's care plan and LHPS task list. -Oxygen therapy was not supposed to be documented as administered in the eMAR system. -She was not aware that Resident #1's order for continuous oxygen at 3 L was not documented on his most recent care plan or LHPS. Interview with the Administrator on 07/19/19 at 9:50am revealed: -She was not aware that Resident #1 had an order for continuous oxygen at 3 L that had not been implemented. -Orders for oxygen should be listed in the care plan assessment and include instructions on how many liters and if the order was for continuous or "as needed." -Resident #1's care plan should have been updated to reflect the new oxygen order. -PCAs and MAs had access at any time to any resident's care plan at the kiosks, located throughout the facility. -There was no requirement for PCAs to view each resident's care plan on a daily basis. -When there was an order change that was updated in the care plan system, an "alert" should be created to bring the new order to everyone's attention. -Because Resident #1's care plan had not been updated with his new order for continuous oxygen at 3 L, there was no alert created to bring the	D 276		

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D 276	Continued From page 6 change to staff member's attention. -The nursing staff was responsible for updating care plans as required when there were significant changes in residents care needs. Telephone interview with a nurse at Resident #1's physician's office on 07/18/19 at 11:21am revealed: - Resident #1 was seen in the physician's office on 05/14/19. -During the visit, Resident #1's oxygen level desaturated to 82% when walking, while he was not wearing any oxygen. -Resident #1's oxygen levels desaturated to 85% when he was "at rest" on 2 L of oxygen per minute. -Resident #1's physician wrote an order for 3 L of continuous oxygen, due to his observations of Resident #1 at the time of the visit. Telephone interview with Resident #1's physician on 07/19/19 at 10:42am revealed: -Resident #1's most recent oxygen order was for 3 L, continuous, written on 05/14/19. -Resident #1 was in "respiratory distress" at the time of the visit on 05/14/19 due to fluid retention. -Prior to the order written on 05/14/19, Resident #1 was wearing oxygen at 2 L, "as needed." -His expectation was that the facility would implement his orders for Resident #1 "immediately." -The facility had not communicated with him regarding Resident #1 not wearing his oxygen continuously at 3 L. -Resident #1 was often non-compliant with orders and in the past he and the resident had "candid conversations" regarding his choices impacting his quality and length of life. -Resident #1 was acutely aware that his decision to not follow orders, such as wearing his oxygen	D 276		

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D 276	Continued From page 7 continuously, could shorten his lifespan, and the resident was comfortable with his decisions to not follow orders.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 1 of 7 sampled residents (#6) regarding orders for a medication used to treat depression. The findings are: Review of Resident #6's current FL2 dated	D 344		

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D 344	Continued From page 8 12/04/18 revealed: -Diagnoses included coronary artery disease, hypertension, and anxiety. -There was an order for sertraline 25mg (used to treat depression), one tablet daily. Review of a subsequent physician's order dated 04/18/19 revealed an order for sertraline 50mg one tablet daily, cancel 25mg dose. Review of a subsequent signed physician's order dated 06/05/19 revealed an order for sertraline 25mg one tablet daily; unsupervised self-administration. Interview with the medication aide (MA) on 07/18/19 at 12:30pm revealed Resident #6 was self-administering her medications until the beginning of July 2019. Interview with the facility's licensed practical nurse (LPN) on 07/18/19 at 2:45pm revealed: -Resident #6 self-administered her medications until she was reassessed by the Resident Care Director (RCD) in the beginning of July 2019. -The facility followed the signed physician's orders signed by the primary care provider (PCP) on 06/05/19. -After Resident #6 was reassessed her medications were placed on the medication cart to be administered by the MA. -She did not know who placed the medications on the cart, but they were supposed to be compared to the eMAR. -The physician was supposed to be notified when the resident was no longer able to self-administer her medications. -The LPN and the RCD were responsible for checking all of the medications before placing them on the cart to be administered by the MAs.	D 344		

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D 344	Continued From page 9 -She did not realize sertraline 50mg was available for administration. -She did not think the eMAR was compared with the medications. -She did not clarify the sertraline order with the PCP. - "This should have been caught, we should have done better". Observation of Resident #6's medications on hand on 07/17/19 at 3:17pm revealed: -There was a bottle of sertraline 50mg tablets with 21 tablets remaining in the bottle with a fill date of 04/18/19. -There was a bubble pack of sertraline 50mg tablets with 30 tablets remaining in the bottle with a fill date of 07/10/19. Review of Resident #6's July 2019 electronic Medication Administration Record (eMAR), from 07/01/19 through 07/17/19 revealed: -There was an entry for sertraline 25mg give one tablet daily at 7:00am. -Sertraline 25mg was documented as self-administered daily at 7:00am from 07/01/19-07/03/19. -Sertraline 25mg was documented as administered daily at 7:00am from 07/04/19 through 07/17/19. Telephone interview with a representative from Resident #6's contracted pharmacy on 07/18/19 at 1:10pm revealed: -Resident #6 was prescribed sertraline 50mg one tablet daily, discontinue 35mg dose on 04/18/19. -There were 90 tablets of sertraline 50mg filled on 04/18/19. -The sertraline 50mg was last filled on 07/10/19, 30 tablets. -The pharmacy did not receive the order for	D 344		

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D 344	Continued From page 10 sertraline 25mg on 06/05/19. Telephone interview with a representative from the facility's contracted pharmacy on 07/19/19 at 10:00am revealed: -Resident #6 was "profile only" and no medications were filled. -The pharmacy entered medications onto the eMAR when the orders were received from the facility. -The pharmacy received an order dated 04/18/19 for sertraline 50mg daily for Resident #6 on 07/18/19. Interview with the first shift medication aide (MA) on 07/18/19 at 12:30pm revealed: -She could not remember how much sertraline she administered to Resident #6 from 07/03/19-07/17/19. -She did not notice Resident #6 had sertraline 50mg on the medication cart available for administration until completing the medication pass on 07/18/19. -She had not compared the medication to the eMAR prior to administering sertraline to Resident #6. -She thought Resident #6 had sertraline 25mg when the resident changed from self-administration, but she could not remember. Attempted telephone interview with Resident #6's primary care provider (PCP) on 07/18/19 at 9:53am was unsuccessful. Interview with the RCD on 07/18/19 at 3:00pm revealed: -Resident #6 previously self-administered her medications until she was reassessed on 07/03/19. -She did not realize Resident #6 had sertraline	D 344		

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D 344	Continued From page 11 50mg available for administration. -Resident #6 was accompanied by family when going to MD appointments and orders were not always given to the facility. -Resident #6 used an outside pharmacy and the family would drop off prescriptions after appointments. -The order dated 04/18/19 for sertraline 50mg was never received by the facility. -She did not catch the medication change during her monthly self-administration assessments. -She did not notice Resident #6 had sertraline 50mg available for administration when medications were removed from the room and placed on the medication cart. - "It was an oversight on our part, we did not catch it." -She and LPNs were supposed to clarify medications with the physician. Interview with the Administrator on 07/19/19 at 9:50am revealed: -She expected the LPNs and the RCD to compare medications to the eMAR when a resident was no longer able to self-administer medications. -The RCD and LPNs should have caught the sertraline 50mg and clarified the medication with the physician.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

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D 358	Continued From page 12 which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 7 sampled residents related to a medication used to treat depression (Resident #3). Review of Resident #3's current FL-2 dated 03/18/19 revealed diagnoses included Parkinson's disease and depression. Review of Resident #3's physician's orders dated 05/14/19 revealed there was a medication order for Celexa (a medication used to treat depression) 10mg one-half tablet (5mg) every morning for seven days and then increase to one tablet (10mg) daily. Review of Resident #3's physician's orders dated 06/06/19 revealed a medication order for Celexa 10mg one tablet daily. Review of Resident #3's physician's orders dated 06/11/19 revealed a medication order to discontinue Celexa 10mg and start Celexa 10mg one and one-half tablets (15mg) daily for seven	D 358		

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D 358	Continued From page 13 days and then increase to 20mg daily. Review of Resident #3's May 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for citalopram hydrobromide (Celexa) 10mg one-half tablet to be administered at 7:00am for seven days with a start date of 05/16/19. -There was documentation Celexa 10mg one-half tablet was administered for seven of seven opportunities from 05/16/19 through 05/22/19. -There was an entry for Celexa 10mg one tablet to be administered at 7:00am with a start date of 05/24/19. -There was documentation Celexa 10mg one tablet was administered for eight of nine opportunities from 05/24/19 through 05/31/19. -There was documentation Celexa was not administered on 05/23/19 with no documented reason. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for Celexa 10mg one tablet to be administered at 7:00am with a start date of 05/24/19 and a discontinue date of 06/11/19. -There was documentation Celexa 10mg one tablet was administered for eleven of eleven opportunities from 06/01/19 through 06/11/19. -There was an entry for Celexa 10mg one and one-half tablets to be administered at 7:00am for seven days with a start date of 06/12/19. -There was documentation Celexa 10mg one and one-half tablets was administered seven of seven opportunities from 06/12/19 through 06/18/19. -There was an entry for Celexa 20mg one tablet to be administered at 7:00am with a start date of 06/20/19. -There was documentation Celexa 20mg one	D 358		

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	HAL060019	A. BUILDING: _____ B. WING _____	07/19/2019

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BRIGHTON GARDENS OF CHARLOTTE	6000 PARK SOUTH DRIVE CHARLOTTE, NC 28210

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D 358	Continued From page 14 tablet was administered for eleven of twelve opportunities from 06/20/19 through 06/30/19. -There was documentation Celexa was not administered on 06/19/19 with no documented reason. Review of Resident #3's July 2019 eMAR from 07/01/19 through 07/17/19 revealed: -There was an entry for Celexa 20mg one tablet to be administered at 7:00am with a start date of 06/20/19. -There was documentation Celexa 20mg was administered for seventeen of seventeen opportunities from 07/01/19 through 07/17/19. Observation of Resident #3's medications available for administration on 07/18/19 at 12:13pm revealed: -There was one bubble pack of Celexa 10mg, with a dispense date of 06/23/19 with four of thirty tablets remaining and a pharmacy label indicating a dose of Celexa 10mg one tablet daily. -There was no direction change sticker on the Celexa 10mg. -There was no Celexa 20mg tablets available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 07/18/19 at 2:29pm revealed: -Resident #3's Celexa was not on a cycle fill and was dispensed when the facility placed an order. -The facility had faxed Resident #3's physician's orders dated 05/14/19 to the pharmacy, and on 05/14/19 the pharmacy had dispensed 26.5 tablets of Celexa 10mg for Resident #3 (a 28 day supply). -The facility had faxed Resident #3's physician's orders dated 06/11/19 to the pharmacy, and on 06/11/19 the pharmacy had dispensed fifteen	D 358		

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D 358	Continued From page 15 tablets of Celexa 10mg for Resident #3 (a 9 day supply). -On 06/23/19, the facility had faxed Resident #3's physician's orders dated 06/06/19 to the pharmacy which had a medication order for Celexa 10mg daily. -On 06/23/19 and 07/16/19, the pharmacy dispensed thirty tablets of Celexa 10mg for Resident #3 which were both "fill errors." -The pharmacy did not realize the physician's orders faxed to them on 06/23/19 were signed and dated prior to the Celexa 20mg order with a start date of 06/20/19. -The pharmacy should have begun dispensing Celexa 20mg tablets for Resident #3 on 06/20/19. -The facility had not contacted the pharmacy regarding the fill error. Interview with the Resident Care Director (RCD) on 07/18/19 at 3:30pm revealed: -She was responsible for providing oversight to the MAs. -The night shift MAs were responsible for checking in medications delivered by the pharmacy. -The MAs would scan each medication as a way of inventorying them. -The MAs were not responsible for comparing a resident's eMAR to the medications received from the pharmacy to assure the correct dosage was sent. -She assumed the pharmacy had assured the dosage was correct prior to sending the medications to the facility. -Medication cart audits were performed by herself and first shift MAs on a monthly basis to assure residents had all medications ordered by their physicians available for administration. -During a cart audit, if they found a medication dose was different on the pharmacy label than	D 358		

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D 358	Continued From page 16	D 358		

what was entered on the eMAR, they would place a sticker on the bubble pack of medication to indicate the change.
-The last audit completed on Resident #3's medications was 07/08/19.
-She did not know why a sticker had not been affixed to the bubble pack of Celexa to indicate the dose had changed to 20mg daily.
-Even though there was no sticker affixed to the bubble pack, the MAs were "probably" administering Celexa 10mg two tablets daily to Resident #3.

Interview with the morning shift medication aide (MA) on 07/18/19 at 3:47pm revealed:
-She worked on the morning and evening shifts as a MA.
-The night shift MAs were responsible for checking in medications delivered by the pharmacy.
-The morning shift MAs were responsible for performing audits on the medication carts.
-When she completed an audit of the medication carts, she compared the medications on the carts to the residents' eMARs and checked for expired medications, discontinued medications and medications with dose changes.
-If she discovered a medication dose was different on the eMAR than the pharmacy label on the bubble pack of medication, she would affix a sticker to the bubble pack with the words "Directions changed, refer to chart" to alert the MAs not to administer the dose on the pharmacy label but instead to administer the dose documented on the eMAR.
-She could not remember the last audit she had completed on Resident #3's medication cart, but she thought it was sometime in early July 2019.
-She did not remember noticing Resident #3's Celexa dose on the medication cart was different

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D 358	Continued From page 17 from the dose on her eMAR during any of her audits. -Even though there was no sticker affixed to Resident #3's bubble pack of Celexa 10mg indicating a change in dose, she had administered Celexa 10mg two tablets to Resident #3 on 07/18/19 because Resident #3's eMAR had Celexa 20mg documented as the current order. Telephone interview with a second morning shift MA on 07/19/19 at 9:10am revealed: -She had worked the night shift until recently when she began working the morning shift. -Night shift MAs were responsible for checking in medications delivered to the facility from the pharmacy. -When medications were delivered from the pharmacy, she would verify she had received all medications documented by the pharmacy as being sent, and she would sign the pharmacy paperwork to indicate so. -She would then sort the medications by medication cart and distribute them to the appropriate cart. -Once at the resident's medication cart, she would scan each resident's medications. -Scanning resident's medications would indicate in the computer system the medication had been received by the facility. -She did not compare the residents' eMAR to the medications being received to assure the dose was correct. If she did so, "it would take her six hours to check in all the medications" and night shift MAs had other responsibilities including performing personal care for residents and attending to emergencies. -It was not the responsibility of the third shift MA checking in medications to assure they were correct, but it was the MA administering	D 358		

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D 358	Continued From page 18 medications responsibility to compare the eMAR to the pharmacy label on the bubble pack prior to administering medications. -As a morning shift MA, she had been administering morning medications to Resident #3 for approximately two months. -She did not realize Resident #3's Celexa dose was 20mg on the eMAR and the Celexa dose available for administration was 10mg. -If she had noticed the dose on the pharmacy label was different from the dose on the eMAR she would have affixed a sticker to the bubble pack of medication to alert MAs to administer the dose on the eMAR. -She knew she should compare the dose on the resident's pharmacy label to the dose on the eMAR prior to administering the medication, but because the morning medication pass was "so heavy," she did not always have time to do so. Attempted telephone interviews with Resident #3's mental health provider on 07/18/19 at 3:00pm and on 07/19/19 at 8:08am were unsuccessful. Attempted telephone interview with Resident #3's primary care provider (PCP) on 07/19/19 at 9:45am was unsuccessful. Interview with the Administrator on 07/19/19 at 8:41am revealed: -The RCD was responsible for providing oversight and training to the MAs. -Third shift MAs were responsible for scanning in medications received from the pharmacy, and they should be comparing the medications received to the residents' eMARs for accuracy. -Medication cart audits were performed weekly by the MAs and monthly by the RCD. -If a medication dose changed, the MAs or the	D 358		

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D 358	Continued From page 19 RCD was responsible for affixing a sticker to the bubble pack of medication to alert the MAs administering medications. -When MAs administered medications, they should be comparing the dose on the eMAR to the dose on the pharmacy label prior to administering the medication. -She did not know why Resident #3 had been administered Celexa 10mg instead of Celexa 20mg for twenty-eight consecutive days.	D 358		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and	D 400		

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D 400	Continued From page 20 (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure pharmacy reviews of medications were completed on site and at least quarterly for 7 of 7 sampled residents (Residents #1, #2, #3, #4, #5, #6, #7). The findings are: 1. Review of Resident #1's current FL2 dated 06/05/19 revealed diagnoses included restrictive thoracic disorder due to morbid obesity, chronic hypercapnic respiratory failure, and acute ongoing chronic diastolic heart failure. Review of Resident #1's Resident Register revealed an admission on 10/05/18. Review of Resident #1's record revealed there was no documentation of a Quarterly Pharmacy Review completed since 01/30/19. Refer to interview on 07/18/19 at 8:40am with the Resident Care Director (RCD). Refer to telephone interview on 07/18/19 at 11:50am with the contracted Pharmacy Consultant Clinical Manager. Refer to interview on 07/18/19 at 2:26pm with the	D 400		

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D 400	Continued From page 21 Administrator. 2. Review of Resident #2's current FL2 dated 12/28/18 revealed diagnoses included repeated falls, anxiety disorder, allergic rhinitis, muscle weakness, and pain unspecified. Review of Resident #2's Resident Register revealed an admission on 12/31/18. Review of Resident #2's record revealed there was no documentation of a Quarterly Pharmacy Review completed since 01/30/19. Refer to interview on 07/18/19 at 8:40am with the Resident Care Director (RCD). Refer to telephone interview on 07/18/19 at 11:50am with the contracted Pharmacy Consultant Clinical Manager. Refer to interview on 07/18/19 at 2:26pm with the Administrator. 3. Review of Resident #3's current FL2 dated 03/18/19 revealed diagnoses included fracture of left femur, wedge compression fracture thoracic vertebrae, Parkinson's disease, fracture of shaft of humerus left arm and depression. Review of Resident #3's Resident Register revealed an admission on 03/29/19. Review of Resident #3's record revealed there was no documentation of a Quarterly Pharmacy Review. Refer to interview on 07/18/19 at 8:40am with the Resident Care Director (RCD).	D 400		

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D 400	Continued From page 22 Refer to telephone interview on 07/18/19 at 11:50am with the contracted Pharmacy Consultant Clinical Manager. Refer to interview on 07/18/19 at 2:26pm with the Administrator. 4. Review of Resident #4's current FL2 dated 06/10/19 revealed diagnoses included dementia, hypertension, benign prostate hypertrophy, pancreatic cyst, vitamin B12 deficiency, and oropharyngeal dysphasia. Review of Resident #4's Resident Register revealed an admission on 08/30/16. Review of Resident #4's record revealed there was no documentation of a Quarterly Pharmacy Review completed since 01/30/19. Refer to interview on 07/18/19 at 8:40am with the Resident Care Director (RCD). Refer to telephone interview on 07/18/19 at 11:50am with the contracted Pharmacy Consultant. Refer to interview on 07/18/19 at 2:26pm with the Administrator. 5. Review of Resident #5's current FL2 dated 07/07/19 revealed diagnoses included spinal stenosis, hypertension, heart disease, gastro-esophageal reflux disease, type 2 diabetes, and dementia without behavior disturbances. Review of Resident #5's Resident Register revealed an admission on 12/29/16.	D 400		

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D 400	Continued From page 23 Review of Resident #5's record revealed there was no documentation of a Quarterly Pharmacy Review completed since 01/30/19. Refer to interview on 07/18/19 at 8:40am with the Resident Care Director (RCD). Refer to telephone interview on 07/18/19 at 11:50am with the contracted Pharmacy Consultant Clinical Manager. Refer to interview on 07/18/19 at 2:26pm with the Administrator. 6. Review of Resident #6's current FL2 dated 12/04/18 revealed diagnoses included coronary artery disease, gastro-esophageal reflux disease, hypertension, anxiety, and diverticulosis. Review of Resident #6's Resident Register revealed an admission on 12/05/18. Review of Resident #6's record revealed there was no documentation of a Quarterly Pharmacy Review completed since 01/30/19. Refer to interview on 07/18/19 at 8:40am with the Resident Care Director (RCD). Refer to telephone interview on 07/18/19 at 11:50am with the contracted Pharmacy Consultant Clinical Manager. Refer to interview on 07/18/19 at 2:26pm with the Administrator. 7. Review of Resident #7's current FL2 dated 07/12/19 revealed diagnoses included multiple sclerosis, age related physical debility, complete regional pain syndrome, chronic embolism and	D 400		

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D 400	Continued From page 24 thrombosis deep vein, and hyperlipidemia. Review of Resident #7's Resident Register revealed an admission on 05/21/12. Review of Resident #7's record revealed there was no documentation of a Quarterly Pharmacy Review completed since 01/30/19. Refer to interview on 07/18/19 at 8:40am with the Resident Care Director (RCD). Refer to telephone interview on 07/18/19 at 11:50am with the contracted Pharmacy Consultant Clinical Manager. Refer to interview on 07/18/19 at 2:26pm with the Administrator. _____ Interview with the RCD on 07/18/19 at 8:40am revealed: -A pharmacy consultant had not come since January 2019. -The pharmacy consultants had notified them after they had made a visit. -She had checked in April and no reports had come in. -She had not called to follow up to find out why the pharmacy consultant had not come. -As of yesterday (07/17/19) the facility had been assigned another pharmacy consultant. -The previous pharmacy consultant had retired. -It was an oversight. Telephone interview on 07/18/19 at 11:50am with the contracted Pharmacy Consultant's Clinical Manager revealed: -The facility had recently been reassigned to another Pharmacy Consultant.	D 400		

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D 400	Continued From page 25 -They had not sent a Pharmacy Consultant since January 2019. -Normally the Pharmacy Consultant would have reached out to the facility to set a date to visit. -A Pharmacy Consultant had not been assigned because of an error with facility assignments. -The facility had reached out to them yesterday to set up a Pharmacy Consultant to visit today. Interview with the Administrator on 07/18/19 at 2:26pm revealed: -The last Pharmacy Consultant had visited in January 2019. -In the past the assigned Pharmacy Consultant had sent her a report after their visit. -She had not received one since the beginning of February 2019. -She had not followed up to see why a report was not sent to her. -She did know it was the responsibility of the facility to ensure pharmacy reviews on all of residents was completed quarterly. -She had not set a reminder for herself to follow up and ensure the pharmacy reviews were completed.	D 400		

Sunrise Senior Living
Plan of Correction

Name of Community: Brighton Gardens of Charlotte
Address: 6000 Park South Drive, Charlotte, NC 28210
License number: HAL-060-019
Inspection date(s): 07/17/2019 – 07/19/2019
Name and Title of Sunrise Representative Signing the Plan of Correction:
Amy Blalock, Executive Director
Signature of Sunrise Representative: Amy Blalock
Date of Submission: 8/29/19

Regulation	Target Date by Which Correction will be completed	Plan of Correction
10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c) (3) of this Rule.		**A. With respect to the specific resident/situation cited:** Resident #1 did not experience a negative outcome as a result of refusing to wear oxygen as ordered by physician. The Wellness Nurse notified physician of resident's refusal to comply with oxygen orders on 07/17/2019. Follow up appointment with pulmonology was completed on 08/01/2019 with new orders, no oxygen needed at rest/exertion. Care Plan update with new oxygen order.
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: The Resident Care Director (RCD)/Wellness Team conducted an audit of residents with oxygen orders on 07/23/2019. Issues identified or observed were addressed and action taken.

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		C. With respect to what systemic measures have been put into place to address the stated concern: The Resident Care Director provided training to the Wellness team on how to update individualized service plans with oxygen order changes; and the process for communicating the changes to the Care Managers and Therapy Team Members by 08/30/2019. The Resident Care director or designee will conduct an audit of residents with oxygen orders for 3 months. The RCD or designee will update individualized service plans as needed to reflect current oxygen orders. At the end of 3 months, the RCD will review and implement additional audits based on the outcome of prior 3 months. Initiated 07/23/2019. The Resident Care director or designee will report findings of the audits, including discussion regarding root cause analysis and process improvement plans and interventions, to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. Initiated 08/28/2019.
	08/28/2019	**D. With respect to how the plan of correction will be monitored:** During and after 3 months, the QAPI Team will re-evaluate the results of the audits and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. Initiated 08/28/2019. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.
10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for medications and treatments: (1) if orders for admission or readmission of		**A. With respect to the specific resident/situation cited:** Resident #6 did not experience a negative outcome as a result of medication delivered. The Wellness Nurse contacted the resident's physician and obtained clarification of medication order and discussed with the physician that the resident no longer meets the criteria to self-medicate and was placed on the community medication program on 07/19/2019. The Wellness Nurse updated the E-mar to reflect the clarified order.

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the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.		The Resident Care Director (RCD) provided coaching and retraining to the Medication Care Managers and Wellness team on the Five Rights of Medication Administration on 07/19/2019.
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: The Resident Care Director conducted an audit on residents who self-administer medication to verify medications are current to physician orders in Sunrise Care Connect/orders. Issues identified or observed were addressed and action taken to verify orders are accurate on 07/27/2019.
		C. With respect to what systemic measures have been put into place to address the stated concern: The Resident Care Director or designee will conducted audits (as listed in B) monthly for 3 months to confirm medication orders are current for resident who self-administer. At the end of the 3 months, the Resident Care Director will review and implement additional audits based on the outcome of the prior 3 months. Initiated on 07/27/2019.

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		The Resident Care director or designee will report findings of the audits, including discussion regarding root cause analysis and process improvement plans and interventions, to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. Initiated on 08/28/2019.
	08/28/2019	**D. With respect to how the plan of correction will be monitored:** During and after 3 months, the QAPI Team will re-evaluate the results of the audits and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.
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 facility's policies and procedures.		**A. With respect to the specific resident/situation cited:** Resident #3 did not experience any negative outcome as a result of the dosage delivered by pharmacy. Identified medication was ordered STAT and physician ordered dose was given in the same evening on 07/18/2019. The Resident Care Director notified ordering physician of pharmacy fill dosage on 07/18/2019. Physician had no instructions or new orders, except to start new dose upon arrival. The Resident Care Director (RCD) provided coaching and re-training to the Medication Care Managers and Wellness team on the Five Rights of Medication Administration on 07/19/2019.

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		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: The Resident Care Director, Medication Care Managers and Wellness Team conducted EMAR to Cart Audits. Issues identified or observed were addressed and action taken. EMAR to Cart audits were initiated on 07/22/2019. In addition, a conference call occurred with the Pharmacy on 07/18/2019 to discuss the necessity of correctly filling physician orders and the protocols for communicating with the community and physician regarding clarification of orders.
		C. With respect to what systemic measures have been put into place to address the stated concern: EMAR to cart audits to be conducted monthly by the Resident Care Director, Medication Care Manager and/or designee to confirm medication and orders are accurate. The Residents Care Director or designee will address and resolve identified issues. The Resident Care director or designee will report findings of the audits, including discussion regarding root cause analysis and process improvement plans and interventions, to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. Initiated on 08/28/2019.

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	08/28/2019	**D. With respect to how the plan of correction will be monitored:** During and after 3 months, the QAPI Team will re-evaluate the results of EMAR to cart audits and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.
10A NCAC 13F .1009(a)(1) Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each		**A. With respect to the specific resident/situation cited:** Residents # 1, #2, #3, #4, #5, #6 and #7 did not experience any negative outcomes as a result of an absence of quarterly pharmacist review. On 07/18/2019 two pharmacist were present at the community to conduct required pharmacy review for residents residing in the community. Recommendations made were faxed to physicians for review and approval or disapproval.

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residents which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medications outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in		

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the resident's record.		
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: The Resident Care Director and Executive Director have established an enhanced tracking system to monitor and confirm pharmacist completes quarterly review as scheduled.
		C. With respect to what systemic measures have been put into place to address the stated concern: The Resident Care Director and Executive Director are tracking to monitor and confirm pharmacist completes quarterly review as scheduled. The Resident Care director or designee will report findings of the pharmacy review to the Quality Assurance Performance Improvement (QAPI) Committee monthly. Initiated 08/28/2019.
	08/28/2019	**D. With respect to how the plan of correction will be monitored:** The Executive Director is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.

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Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.