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
	HAL092024	A. BUILDING: _____ B. WING _____	08/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF RALEIGH	3101 DURALEIGH ROAD RALEIGH, NC 27612

(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 August 20-22, 2019.	D 000		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 8 ounces of milk was served twice daily to residents on the Assisted Living Unit (ALU) and the Special Care Unit (SCU). The findings are: Review of the facility's Weekly Menu for 08/20/19 revealed 8 ounces of milk was to be served to the residents at breakfast and dinner. Review of the facility's Weekly Menu for 08/21/19 revealed 8 ounces of milk was to be served to the residents at breakfast and dinner. Observation on 08/21/19 at 8:10 am of the kitchen's refrigerator revealed there were 2 full gallons of milk and 9 full half gallons of milk in the	D 299	Residents observed in the dining room did not experience a negative outcome as a result of not receiving milk during the meals. Once this issue was identified, the Associate Executive Director (AED) and Reminiscence Coordinator (RC) conducted refresher training sessions the process for offering milk, for Care Managers and Dining Team Members. The RC and the AED conducted the same refresher training for the care managers and staff in the memory care neighborhood regarding the process for providing milk. Following the refresher training with the care managers and dining room team members, the AED conducted unannounced observations of dining room service to confirm milk was being offered and provided in both neighborhoods. No issues were identified. The Coordinators have received refresher training conducted by the AED or designee regarding the provision of milk per regulation and their responsibilities for providing dining oversight. A Department Coordinator dining room oversight schedule has been developed by the AED. The oversight consists of observing meals in the main and Reminiscence Dining rooms to confirm milk is offered and/or provided daily at 2 meals. This oversight will occur for 3 months. The AED or designee will present the findings of the dining room observations monthly for 3 months at Quality Assurance Performance Improvement (QAPI) meetings.	8.23.19 .25.19

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director 10/7/19

Nathan Robison

STATE FORM 6899 4MLL11 If continuation sheet 1 of 14

POC reviewed and accepted on 10/7/19
D. Dawson-Rogers

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D 299	Continued From page 1 refrigerator. 1. Observation of the lunch meal on 08/20/19 on the ALU between 11:30 am and 12:15 pm revealed: -There were 24 residents seated in the dining room for the first lunch. -Residents were served water, tea and plated meals. -Milk was not served or offered to the residents to drink with their meal. Observation of the dinner meal on 08/20/19 on the ALU between 4:30 pm and 5:15 pm revealed: -There were 21 residents seated in the dining room for dinner. -Resident were served water, tea and plated meals. -Milk was not served or offered to the residents to drink with their meal. Interviews with 4 residents on 08/20/19 between 11:30 am and 12:15 pm seated at a table near the entrance of the dining room revealed: -Residents were only served milk during the breakfast meal if they were eating cereal. -Residents were not served or offered milk during the lunch or dinner meal. -Residents had to ask for milk before it would be served. Observation of the breakfast meal on 08/21/19 on the ALU between 7:30 am and 8:00 am revealed: -There were 21 residents seated in the dining room for breakfast. -Residents were served water and orange juice for the breakfast meal. -Milk was served to 5 residents with their cereal and 1 resident who gets milk automatically. Milk was not offered to other residents to drink with	D 299	During and after 3 months, the QAPI Team will evaluate the findings of the Department Coordinator dining room observations and may extend the review period, as needed based on issues identified or trends observed. The Executive Director or designee is responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.	9.25.19 8.23.19

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D 299	Continued From page 2 their meal. Interviews with 3 residents on 08/21/19 between 8:30 am and 8:55 am revealed: -Residents were only served milk during the breakfast meal if they were eating cereal. -Residents were not served or offered milk during the lunch or dinner meal. -Residents had to ask for milk before it would be served. -They would drink milk if it was offered to them. Interview with a dietary aide on 08/21/19 at 8:15 am revealed: -Milk was not served or offered to the residents during meals. -Milk was only served during the breakfast meal to residents eating cereal. Interview with a second dietary aide on 08/21/19 at 8:55 am revealed: -Only water, orange juice, cranberry juice, and prune juice were offered with the breakfast meal. -Milk was only served to the residents eating cereal during the breakfast meal. -If the residents wanted milk, they would ask for it. -After a while you get to know what the residents want to drink with their meals. Interview with a cook on 08/21/19 at 8:15 am revealed: -He did not know if residents were served milk with meals. -He did not know milk should be served twice daily to the residents. -The dietary aides are responsible for offering beverages to the residents with their meals. Interview with the Administrator on 08/21/19 at	D 299		

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D 299	Continued From page 3 9:00 am revealed: -She did not know the kitchen staff was not following the menu for milk. -She did not know the kitchen staff only serve milk during the breakfast meal to the residents eating cereal. -The residents should be served or offered milk twice daily on the Assisted Living Unit. -If residents did not like milk then an acceptable substitute should be offered. -It was the dietary aide's responsibility to serve or offer milk. -She expected milk to be served or offered twice daily following the menu. 2. Review of the facility's Weekly Menu for 08/20/19 revealed 8 ounces of milk was to be served to the residents on the SCU at breakfast and dinner. Review of the facility's Weekly Menu for 08/21/19 revealed 8 ounces of milk was to be served to the residents on the SCU at breakfast and dinner. Observation of the lunch meal on 08/20/19 on the SCU between 11:45 am and 12:45 pm revealed: -There were 19 residents seated in the dining room for lunch. -Residents were served water, tea and plated meals. -Milk was not served or offered to the residents to drink with their meal. Observation of the dinner meal on 08/20/19 on the SCU between 4:30 pm and 5:00 pm revealed: -There were 20 residents seated in the dining room for dinner. -Residents were served water, tea and plated meals. -Milk was not served or offered to the residents to	D 299		

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D 299	Continued From page 4 drink with their meal. Observation of the breakfast meal on 08/21/19 on the SCU between 8:00 am and 9:00 am revealed: -There were 20 residents seated in the dining room for breakfast. -Residents were served water, tea and plated meals. -Only one resident was served milk on 08/21/19 during the breakfast meal. -Milk was not offered to the other residents to drink with their meal. Interview with a private sitter on 08/20/19 at 5:00 pm revealed: -Milk was not served to the resident on 08/20/19 during the dinner meal. -The resident was served water and tea. Interview with the same private sitter on 08/21/19 at 8:45 am revealed: -Milk was not served to the resident on 08/21//19 during the breakfast meal. -The resident was served water and tea. Interview with a Lead Care Manager (LCM) on 08/21/19 at 4:22 pm revealed: She did know milk was not served to the SCU residents on 08/20/19 during the lunch and dinner meal and on 08/21/19 during breakfast meal. -Staff had brought it to her attention on 08/21/19. -The residents should be served milk during the breakfast and lunch meals. -She would assure milk was served to the residents two times a day. Interview with a second LCM on 08/22/19 at 4:04 pm revealed: -She did not know that milk was not served to the residents on the SCU on 08/20/19 during the	D 299		

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D 299	Continued From page 5 lunch and dinner meal and on 08/21/19 during breakfast meal. -Milk should be served with all meals. -She did not know why milk was not served on 08/20/19 during the lunch and dinner meal and on 08/21/19 during the breakfast meal. Interview with the Reminiscence Coordinator (RC) on 08/22/19 at 4:15 pm revealed: -She did know milk was not served to the residents on the SCU on 08/20/19 during the lunch and dinner meal and on 08/21/19 during breakfast. -The residents on the SCU were offered milk on 08/20/19 during the lunch and dinner meal and on 08/21/19 during the breakfast meal. -She did not know that the residents on the SCU had to be served milk two times a day. -She would assure the residents on the SCU were served milk two times a day. Interview with the Administrator on 08/22/19 at 6:00 pm revealed: -She did know milk was not served to the residents on the SCU on 08/20/19 during the lunch and dinner meal and on 08/21/19 during the breakfast meal. -Staff had brought it to her attention on 08/21/19. -The residents on the SCU would be served milk two times a day.	D 299		
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:	D 358		

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D 358	Continued From page 6 (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 residents observed during the 8:00am medication pass on 08/21/19 related to overactive bladder medication (#9) and a pain reliever (#8). The findings are: The medication error rate was 6% as evidenced by the observation of 2 errors out of 30 opportunities during the 8:00 am medication pass on 08/21/19. 1. Review of Resident #9's current FL2 dated 10/05/18 revealed: -Diagnosis included osteoarthritis, hypertension and surgery on nervous system for cerebrospinal fluid drainage device. -There was an order for Myrbetriq Extended Release 25 mg one tablet daily (Myrbetriq is used to treat overactive bladder which causes frequent urination).	D 358	Resident #9 and Resident #8 did not experience a negative outcome as a result of medication administration findings. For resident #9 the Resident Care Director (RCD) immediately clarified order with the physician and adjusted the order dosage on the E-Mar. For resident #8, the RCD contacted the physician and no new orders were issued. The RCD confirmed that the medication arrived the day of the survey from the pharmacy and Resident #8 received the next scheduled dose. The responsible parties of both Residents #8 and #9 were contacted and informed by the RCD or designee RCD, Wellness Nurses (WN) and Medication Care Managers (MCM) conducted an EMAR to Cart audit to confirm medication availability and appropriate dosage of medications per physician orders Issues identified or observed were addressed and action taken to verify medication availability and dosage per physician orders. EMAR to cart audits will be conducted weekly for 1 month and monthly for 2 months by the RCD and/or designee to confirm medication availability and appropriate dosage of medications per physician orders The RCD or designee will address and resolve issues identified.	8.21.19 8.21.19 8.21.19 8.30.19 8-23-19 9.4.19

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D 358	Continued From page 7 Observation of the 8:00 am medication pass on 08/21/19 revealed: -At 8:40 am, the morning medication aide (MA) prepared 6 oral medications for administration to Resident #9. -The MA administered the 6 oral medications, including one Myrbetriq 25mg tablet to Resident #9. Review of Resident #9's physician's order dated 04/15/19 revealed an order for Myrbetriq Extended Release 25 mg one tablet daily. Review of Resident #9's physician's order dated 06/05/19 revealed an order for Myrbetriq Extended Release 50 mg one tablet daily. Review of Resident #9's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Myrbetriq Extended Release 25 mg one tablet daily and scheduled for 8:00 am. -Myrbetriq Extended Release 25 mg one tablet daily was documented as administered at 8:00 am daily from 08/01/19 to 08/21/19. -There was no entry for Myrbetriq Extended Release 50 mg one tablet daily listed on the eMAR. Observation of Resident #9's medications on hand on 08/21/19 at 8:40 am for administration revealed; -There was a bingo card labeled Myrbetriq Extended Release 25 mg one tablet daily dispensed on 06/04/19 for 30 tablets with 19 tablets remaining included in the resident's current medications on the medication cart. -There was a bingo card labeled Myrbetriq	D 358	The RCD conducted refresher trainings with MCMs on confirming medication availability and physician ordered dosages and communicating issues to the RCD or Wellness Nurse The RCD conducted refresher training for the Wellness Nurses on the process for clarifying physician orders and confirming that the orders are accurately reflected on the eMAR. The RCD or designee will present the findings of medication cart and EMAR audits monthly for 3 months at the Quality Assurance Performance Improvement (QAPI) meetings During and after 3 months, the QAPI Team will re-evaluate the results of the Medication Cart and eMAR 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.	9.4.19 9.4.19 9.24.19 9.25.19 9.25.19

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D 358	Continued From page 8 Extended Release 50 mg one tablet daily dispensed on 07/27/19 for 30 tablets with 30 tablets remaining located in the resident's overstock medications, but not on the medication cart. Telephone interview with a representative for the contracted pharmacy on 08/21/19 at 11:20 am revealed: -The pharmacy received the electronic order for Myrbetriq Extended Release 50 mg one tablet daily on 06/05/19 from Resident #9's physician's office. -The pharmacy had documentation Myrbetriq Extended Release 25 mg one tablet daily was last dispensed for 30 tablets on 06/04/19. -The pharmacy had documentation Myrbetriq Extended Release 50 mg one tablet daily was dispensed for 30 tablets on 06/05/19, 07/01/19, and 07/27/19. -The pharmacy filled residents' medication orders based on information received directly from the residents' prescribers or from orders sent by the facility to the pharmacy. -The pharmacy did not generate the residents' eMARs. -The facility generated the residents' eMARs. -The pharmacy maintained medication profiles and sent medications for residents, but was not able to correct or change the facility's eMARs. -The facility was responsible to maintain accurate residents' eMARs. Interview with the morning medication aide (MA) on 08/21/19 at 12:45 pm revealed: -She administered medications according to directions on the eMAR. -The Wellness Nurses were responsible to enter orders on the residents' eMARs and to send medication orders to the contracted pharmacy for	D 358		

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D 358	Continued From page 9 filling. -She administered Myrbetriq Extended Release 25 mg at 8:00 am as ordered on the eMAR. -She did not know ther was an order change to 50 mg since the Wellness Nurses received, reviewed and changes medications on the eMAR. Interview with the Resident Care Director (RCD) on 08/21/19 at 12:10 pm revealed: -The RCD was responsible to assure medications were administered as ordered to residents. -The RCD had 2 Wellness Nurses (WN) that were responsible to enter orders on the residents' eMARs for the MAs to administer the medications. -The WN on duty at the time should have entered Myrbetriq Extended Release 50 mg on Resident #9's eMAR and discontinued the order for Myrbetriq Extended Release 25 mg. -The order dated 06/05/19 for Myrbetriq Extended Release 50 mg appeared to be a copy of the electronic order sent directly to the pharmacy by the provider. A copy of orders received electronically by the pharmacy was routinely forwarded to the facility to assure the order was received by the facility and the facilty made eMAR changes. -The Myrbetriq Extended Release 50 mg order must have gotten filed in Resident #9's record without the WD on duty transcribing the order to the resident's eMAR. -The MA staff apparently administered Myrbetriq Extended Release 50 mg for June 2019 and July 2019 even though the eMAR listed 25 mg to be administered, until the MA pulled the bubble package of Myrbetriq Extended Release 25 mg dispensed on 06/04/19 (before the change to 50 mg) and administered 25mg including on 08/21/19. -The RCD had not done an audit for Resident	D 358		

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D 358	Continued From page 10 #9's medications on the cart compared to the current medications orders. Interview with Resident #9 on 08/21/19 at 1:00 pm revealed: -She did not know the strength of her "bladder" medication. -She did recognize the name and color of the tablet. -She did not know the Nurse Practitioner (NP) increased the strength of Myrbetriq, but she would be glad to try anything that kept her from having to get up during the night to go to the bathroom. Refer to interview with the Administrator on 08/22/19 at 5:45 pm. 2. Review of Resident #8's current hospital FL2 dated dated 07/08/19 revealed diagnoses included acute shortness of breath, hypertension, uncontrolled, dementia, and chronic anemia. Review of Resident #8's record revealed: -There was a physician's encounter sheet dated 08/12/19 with documentation the resident was seen for low back pain. There was an order to start tramadol 50 mg one-half (1/2) tablet twice a day for 10 days for back pain (used to treat moderate pain). -There was a prescription order for tramadol 50 mg one-half (1/2) tablet twice a day for 10 days for back pain handwritten for Resident #8. Observation of the 8:00 am medication pass on 08/21/19 revealed: -At 9:00 am, a second morning medication aide (MA) prepared 10 oral medications for administration to Resident #8. -The MA administered the 10 oral medications to	D 358		

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D 358	Continued From page 11 Resident #9 (not including tramadol). Interview with the MA that administered Resident #8's morning medications on 08/21/19 at 9:00 am revealed Resident #8 had tramadol 25mg ordered for 10 days and the order was completed yesterday (08/20/19). Review of Resident #8's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for tramadol 50 mg 0.5 (one-half) tablet two times a day for pain for 10 days scheduled for administration at 8:00 am and 8:00 pm daily beginning at 8:00 pm on 08/12/19 and ending on 08/22/19 at 8:00 am. (Documentation areas before the beginning doses and after the ending doses had "X" to denote no administration required.) -There was documentation of 14 doses (7 days) of tramadol 50 mg one-half tablet as administered from 8:00 am on 08/13/19 to 8:00 pm on 08/19/19. -"Course completed" was documented on 08/20/19 at 8:00 pm and 08/21/19 at 8:00 am. Observation of Resident #8's medications on hand for administration on 08/21/19 at 3:20 pm revealed a bubble package was dispensed on 08/21/19 labeled for tramadol 50 mg one-half tablet twice a day for 10 days, with 6 of 6 one-half tablets remaining in the bubble package. Telephone interview with a representative for the contracted pharmacy on 08/21/19 at 11:20 am revealed: -The pharmacy dispensed 7 tablets (14 doses of one-half tablet twice a day) on 08/12/19 which was 7 days worth of tramadol 50 mg. Due to current regulations, only a 7 day supply of pain	D 358		

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(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 358	Continued From page 12 medications could be dispensed on the first dispensing, followed by the remainder of the medication if the resident tolerated the medication. -The pharmacy dispensed the additional 3 days (6 of one-half tablet doses) on 08/20/19 to complete the 10 day course of therapy ordered. Interview with the Resident Care Director (RCD) on 08/21/19 at 12:10 pm revealed: -The RCD was responsible to assure medications were administered as ordered to residents. -The RCD had 2 Wellness Nurses (WN) that were responsible to enter orders on the residents' eMARs for the MAs to administer the medications. -The WN on duty at the time entered the order for Resident #8's 10 day therapy course for tramadol 50 mg one-half tablet twice a day for 10 days, and indicated a stop and start administration with the days before therapy and after therapy blocked out per the routine way orders with specific length of therapy were entered on the eMAR. -She did not know staff did not administer tramadol for Resident #8 for the designated length of therapy. -The contracted pharmacy did not alert her of changes to the dispensing limits regarding pain medications in order for her to pass along to the staff. -The MA staff were supposed to contact the Wellness Nurses or the RCD for any question regarding medication administration to residents. Interview MA that administered Resident #8's morning medications on 08/21/19 at 12:20 pm revealed: -She did not know the pharmacy sent only part of Resident #8's tramadol 50 mg full 10 day therapy course.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092024	A. BUILDING: _____ B. WING _____	08/22/2019

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BRIGHTON GARDENS OF RALEIGH	3101 DURALEIGH ROAD RALEIGH, NC 27612

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D 358	Continued From page 13 -Routinely, the pharmacy sent the prescribed days of therapy included in the bubble package when a medication was sent for a designated period of time. -Occasionally in the past, the Wellness Nurses had not blocked the correct length of therapy on the eMAR and she thought when she gave the last dose from the bubble package sent from the contract pharmacy, Resident #8's order for tramadol was complete. -She had not discussed tramadol 50 mg documentation on the eMAR with the Wellness Nurses or the RCD. -She had seen the bubble package with 6 additional doses dispensed on 08/21/19, but thought the resident had already finished 10 days. - -She had not told or asked anyone about the tramadol running out before the administration documentation indicated on the eMAR were complete. Interview with Resident #8 on 08/21/19 at 12:30 pm revealed: -She was not sure how long she was supposed to take the new pain medication (tramadol). -She did not think the tramadol helped very much with her back pain. -She would take the additional doses of tramadol if they were offered as scheduled. Refer to interview with the Administrator on 08/22/19 at 5:45 pm. Interview with the Administrator on 08/22/19 at 5:45 pm revealed the Wellness nursing staff were responsible for assuring medications were administered as ordered with the Resident Care Director overseeing the Wellness Nurses.	D 358		