STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ASHEVILLE WALDEN RIDGE	4 WALDEN RIDGE DRIVE ASHEVILLE, NC 28803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual and follow up survey and complaint investigation on 04/21/22 and 04/22/22 with an exit conference via telephone on 04/25/22. The complaint investigation was initiated by the Buncombe County Department of Social Services on 04/20/22.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#5) which resulted in a resident eloping from the facility. The findings are: Review of Resident #5's current FL2 dated 12/14/21 revealed: -Diagnoses included Alzheimer's disease, major depressive disorder, atherosclerotic heart disease (a build up of plaque in the arteries causing the obstruction of blood flow). -She was ambulatory. -She was constantly disoriented and documented wandering behaviors.	D 270		

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D 270	Continued From page 1 -The recommended level of care was documented as Special Care Unit (SCU). Review of Resident #5's Licensed Health Professional Support (LHPS) quarterly review dated 01/27/22 revealed she ambulated independently without any device. Review of Resident #5's Care Plan dated 02/22/22 revealed: -The resident wandered and required redirection. -The resident was documented as not always oriented to place and time. -The resident attempted to exit the facility without needed supervision. -The staff needed to be alert to resident's a pattern and reason for exit attempts, (e.g. involve in meaningful activities prior to end of a party as families leave so she will not follow out of facility). -It was documented Resident #5 goes to exits doors but was often easily redirected. -There was no documentation of care plan being updated with interventions after resident eloped on 03/26/22. Review of a faxed document to the local county department of social services Adult Home Specialist on 03/28/22 revealed: -Resident #5 had eloped on 03/26/22. -Resident #5 was seen in the parking lot by a staff member at approximately 6:45pm on 03/26/22. -Based on timeline staff they believed she was outside for 1-2 minutes and exited doors after paramedics left the facility for a different situation. -Follow up was documented as skin check, head count, alarms investigation, staff training and root cause analysis. Review of the electronic medication	D 270		

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administration record notes for Resident #5 revealed:
-There was an entry dated 03/26/22 at 8:16pm.
-The resident "slipped out the front door" this evening.
-It was documented another resident went out via ambulance along with their family leaving, she slipped out too.
-It was documented the Power of Attorney (POA) was notified and was told what happened and that staff looked her over and she was resting, and the resident was out for a minute or two before staff noticed the resident was outside.
-The Executive Director (ED) and the nurse were notified.

Review of the recorded weather report for the Asheville Regional Airport revealed:
-On 03/26/22 the temperature at 5:54pm was 24 degrees Fahrenheit (F) with wind gust of 35.7 mile per hour (mph).
-On 03/26/22 the temperature at 6:54pm was 21 degrees F with wind gust of 35.7 mph.

Interview with a personal care aide (PCA) on 04//22 at 3:11pm revealed:
-Resident #5 had to frequently be redirected from the exit door.
-Staff tried to get Resident #5 to watch a movie or stay away from the door because she would constantly "eyeball the door".
-She was working the evening of 03/26/22 when Resident #5 got out of the facility.
-She had been helping another resident in the bathroom when she heard an alarm but could not leave the resident she was assisting in the bathroom.
-When she finished in the bathroom with the resident, she and 2 other staff members were in the front lobby.

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D 270	Continued From page 3 -While they were standing in the front lobby talking, they noticed Resident #5 outside of the the facility. -The PCA went outside across the parking lot and up the hill almost to the road, in the mulch area, near the facility sign to get Resident #5. -It was cold outside and almost dark. -The hill was pretty steep so she held Resident #5's hand and assisted her back into the building. -The medication aide (MA) who was working that night had been assisting with the resident who was going out via ambulance. -She and another aide took Resident #5 back to her room and checked her out good, the resident was ok, just very cold. The PCA and the other aide did not know how Resident #5 had walked out of the facility as staff were the only ones with the door code to let visitors in and out of the facility. -There was no ambulance in the front of the building as it had already left before she and the other aides were talking in the front lobby area so the resident had to have been outside longer than 1-2 minutes. Interview with the MA on 04/21/22 at 4:45pm revealed: -She was working on 03/26/22 when Resident #5 eloped from the facility. -She had been assisting another resident. -She did not see the ambulance leave nor did she see Resident #5 leave the facility. -A resident had been sent out to the hospital around 6:30pm, another resident asking for Tylenol, and a staff member was leaving due to a family emergency on 03/26/22. -No one saw Resident #5 go outside. -She thought Resident #5 had maybe followed the emergency personnel or family went out, but	D 270		

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D 270	Continued From page 4 she did not know for sure because she was in the dining room charting on the resident who had left for the hospital. -It was her understanding staff saw Resident #5 outside, went outside and brought Resident #5 back in the facility. -Staff took Resident #5's vitals and did a skin check. -She notified the family, physician and the Executive Director. Interview with Resident #5's family member on 04/22/22 at 1:50pm revealed: -The facility had called her on 03/26/22 after the incident and notified her Resident #5 had followed the emergency personnel or visitors out of the facility and Resident #5 was probably outside for a minute or two. -She had also been told Resident #5 was getting ready to go across the sidewalk heading for the police station across the street when staff brought her back in. -She did not understand how Resident #5 left the facility as the code is not given out to family members and staff have to put in the code in to open the door. -Staff could not tell her how Resident #5 got out only their best guess of how they thought Resident #5 got out or how long she was outside. -If Resident #5 had followed them out where was the staff member who put in the code to let them out. -She had observed on many of her visits staff put the code in and then they walk off without ensuring the door was secure. -This was the second time Resident #5 had left the facility unsupervised. -The first time Resident #5 left the facility was in October 2021.	D 270		

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D 270	Continued From page 5 Interview with the Administrator on 04/22/22 at 12:05pm revealed: -She was told by staff Resident #5 had followed emergency personnel or the family of the resident who went to the hospital out of the facility and Resident #5 had only been outside for a minute or two. -She was not aware of the door alarm sounding that evening because it took several staff to reset the door alarm if it sounded. -Staff would have also been aware as the alarm is extremely loud. -Since 03/14/22 she had also observed staff on various occasions staff going to the front door, entering the code and then walking off before the person exited or entered the facility and the door was secured but had not addressed it with staff as she was new to the facility. -They had checked the alarms, provided increased checks on Resident #5 and involved her in more activities but the facility had not documented anything they done. -She had recommended an updated alarm system and administrative staff were educating new staff regarding any employee who opened the front door was responsible to ensure the door was shut and secure beginning 04/22/22. -The HWD was responsible for updating Resident #5's care plan and the interventions the facility had put in placed. -The HWD was not available . Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. Attempted telephone interview with the HWD on 04/22/22 at 10:00am was unsuccessful.	D 270		

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D 358	Continued From page 6	D 358		
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 observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#3 and #4) related to a medication that treats dementia (#4) and medications to treat constipation and nausea (#3). Review of the facility's General Guidelines for Medication Administration revised 04/2022 revealed: -Medications should be administered per the healthcare provider's order. -Medication directions on the physician's order and pharmacy label should correlate with the medication on the electronic Medication Administration Record (eMAR). 1. Review of Resident #4's current FL2 dated 02/01/22 revealed: -Diagnoses included vascular dementia. -Medication orders included memantine 10mg twice daily. Review of Resident #4's Resident Register revealed: -There was no admission date.	D 358		

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D 358	Continued From page 7 -Resident #4's responsible person had signed and dated the form on 02/02/22. Review of a physician's order for Resident #4 dated 02/22/22 revealed discontinue memantine 10mg twice daily and start memantine 10mg daily at bedtime. Review of Resident #4's electronic Medication Administration Record (eMAR) for 02/22/22 - 04/20/22 revealed there was an entry for memantine 5mg daily at bedtime at 8:00pm and documentation of administration on 02/22/22 - 04/20/22 at 8:00pm. Observation of Resident #4's medications on hand on 04/21/22 at 4:38pm revealed: -There was one bubble pack labeled memantine 10mg one tablet at bedtime. -Thirty tablets had been dispensed on 04/02/22 and 10 tablets remained. -Handwritten beside the label on the bubble pack was "1/2 tab" (5mg tablet). Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 04/21/22 at 3:10pm revealed: -The facility had received a faxed physician's order from the facility on 02/22/22 to discontinue memantine 10mg twice daily and start memantine 10mg daily at bedtime. -The pharmacy did not enter medication orders into the eMAR system. -The facility's corporate policy was that the pharmacy could not access the eMAR. -The facility's staff entered medication orders into the eMAR system. -New orders were faxed to the pharmacy so that the medications could be dispensed.	D 358		

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Interview with a second shift Medication Aide (MA) on 04/21/22 at 4:47pm revealed:
-She had written the notation on the memantine bubble pack.
-She had compared the bubble pack to the order in the eMAR and thought the dose to be 5mg.
-She had cut the memantine 10mg tablet in half and administered the 5mg to Resident #4.
-The facility nurse was responsible for entering new medication orders into the eMAR system.
-She did not know if another staff was checking behind the nurse to ensure accuracy of the eMAR.

Interview with a nurse on 04/21/22 at 4:50pm revealed:
-Nurses and MAs were able to enter new medication orders in to the eMAR system.
-She did not know if another staff checked the newly entered orders for accuracy.

Telephone interview with the Health and Wellness Director (HWD) on 04/22/22 at 8:40am revealed:
-She did not remember if she had entered the memantine order into the eMAR system.
-Sometimes another staff would check behind to ensure the medications were entered accurately.
-There was not a dedicated staff to audit new orders that were entered into the eMAR to ensure accuracy.
-The facility's contracted pharmacy conducted medication cart audits monthly.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 04/22/22 at 9:26am revealed:
-Resident #4 was prescribed memantine for dementia.
-He was in the process of slowly decreasing Resident #4's memantine dose as it was

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contraindicated in advanced dementia.
-The memantine should not be stopped abruptly.

Based on observation, interview, and record review Resident #4 was not interviewable.

Refer to the interview with the Administrator on 04/22/22 at 8:56am.
2. Review of Resident #3's current FL2 dated 06/28/21 revealed diagnoses included dementia and alcohol dependence.

Review of Resident #3's Resident Register revealed he was admitted on 07/01/21.

a. Review of signed physician orders for Resident #3 dated 08/18/21 revealed polyethylene glycol 17gms was to be given daily for constipation.

Review of Resident #3's hospital discharge summary dated 02/22/22 revealed polyethylene glycol 17gms was to be administered every night at bedtime as needed for constipation.

Review of Resident #3's February 2022, March 2022, and April 2022 electronic Medication Administration Records (eMAR)s revealed polyethylene glycol 17gms was administered daily at 8:00am from 02/01/22 to 04/21/22 except from 02/17/22 to 02/22/22 due to the resident being hospitalized.

Observation of medications on hand for Resident #3 on 04/22/22 at 10:25am revealed there was no polyethylene glycol available for administration.

Interview with a nurse on 04/22/22 at 10:25am revealed:
-She was agency staff and had worked at the facility consistently since January 2022.

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D 358	Continued From page 10 -The Health and Wellness Director (HWD) or the Medication Aide (MA) on duty was responsible for entering new or changed medication orders into the eMAR system when a resident returned to the facility after a hospital discharge. -She thought the HWD reviewed Resident #3's discharge summary. -She was unsure if orders were reviewed by two staff members to ensure medication orders were entered accurately. -She was asked one time to review a resident's order for accuracy because it was a controlled substance. -Resident #3's polyethylene glycol was not available for administration because it was on order from the pharmacy. -She planned to call the pharmacy to see when the medication would be delivered. Telephone interview on 04/22/22 at 11:01am with a pharmacist at the facility's contracted pharmacy revealed: -Polyethylene glycol 17gms daily was prescribed for Resident #3 on 10/23/21. -The pharmacy received a new order from Resident #3's hospital discharge summary on 02/23/22. -The new order on 02/23/22 was polyethylene glycol 17gms at bedtime as needed. -The facility staff were responsible for entering orders in the eMAR system. -Polyethylene glycol 238gms was dispensed on 10/23/21 and 510gms was dispensed on 04/02/22 for Resident #3. Telephone interview on 04/22/22 at 9:27am with Resident #3's Primary Care Provider (PCP) revealed: -Resident received polyethylene glycol 17gms daily for constipation.	D 358		

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-He expected orders to be placed on the eMAR accurately when a resident was discharged from the hospital.
-He expected medications to be administered as ordered.

Refer to the interview with the Administrator on 04/22/22 at 8:56am.

Attempted telephone interview with the HWD on 04/22/22 at 10:06am was unsuccessful.

Based on observation, interview, and record review Resident #3 was not interviewable.

b. Review of a physician's order for Resident #3 dated 02/16/22 revealed Zofran 4mg was to be given every six hours as needed for three days for nausea and vomiting.

Review of progress note dated 02/16/22 at 4:26pm revealed Resident #3 had a fall and was sent to the hospital.

Review of Resident #3's hospital discharge summary dated 02/22/22 revealed no order for Zofran.

Review of Resident #3's February 2022 electronic Medication Administration Record e(MAR) revealed:
-There was an entry for Zofran 4mg every six hours as needed for nausea and vomiting for three days, from 02/16/22 to 02/19/22.
-There was no documentation the Zofran was administered from 02/16/22 to 02/19/22.
-There was an entry beginning 02/24/22 for Zofran 4mg every six hours as needed for nausea.
-The medication was documented as

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D 358	Continued From page 12 administered once on 02/26/22 and 02/27/22. Review of Resident #3's March 2022 eMAR revealed: -There was an entry for Zofran 4mg every six hours as needed for nausea. -The medication was documented as administered once on 03/01/22, 03/02/22, 03/03/22, and 03/11/22. Review of Resident #3's April 2022 eMAR revealed: -There was an entry for Zofran 4mg every six hours as needed for nausea. -There was no documentation the Zofran was administered from 04/01/22 to 04/21/22. Observation of medications on hand for Resident #3 on 04/22/22 at 10:25am revealed there was no Zofran 4mg available for administration. Interview with a nurse on 04/22/22 at 10:25am revealed: -She was agency staff and had worked at the facility consistently since January 2022. -After Resident #3 returned from the hospital she spoke with his Primary Care Provider (PCP) and received a verbal order for Zofran 4mg every six hours as needed. -She thought she filled out a telephone order form and faxed it to the pharmacy. -She placed the new order in Resident #3's eMAR. -All telephone orders were placed in a binder for the PCP to sign after they were faxed to the pharmacy. -She was unable to locate the Zofran order for Resident #3. -She had Zofran 4mg on hand for Resident #3 from the previous order dated 02/16/22.	D 358		

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D 358	Continued From page 13 -She was unsure if orders were reviewed by a second staff member to ensure orders were entered accurately into the eMAR system. Telephone interview on 04/21/22 at 3:47pm with a pharmacy technician at the facility's contracted pharmacy revealed: -The pharmacy received an order for Resident #3 on 02/16/22 for Zofran 4mg every six hours as needed for three days. -Zofran 4mg, 12 tablets were dispensed to the facility on 02/16/22. -The facility's staff entered medication orders into the eMAR system. -They had not received any additional orders for Zofran for Resident #3. Telephone interview on 04/22/22 at 9:27am with Resident #3's Primary Care Provider (PCP) revealed: -He prescribed Zofran for Resident #3 on 02/16/22 for nausea and vomiting. -He was unsure if he gave any other Zofran orders for Resident #3. -He expected orders to be placed on the eMAR accurately when a resident was discharged from the hospital. -He expected medications to be administered as ordered. Refer to the interview with the Administrator on 04/22/22 at 8:56am. Attempted telephone interview with the HWD on 04/22/22 at 10:06am was unsuccessful. Based on observation, interview, and record review Resident #3 was not interviewable. Interview on 04/22/22 at 8:56am with the	D 358		

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D 358	Continued From page 14 Administrator revealed: -The HWD or the MA on duty was responsible to enter hospital discharge orders into the eMAR system. -She did not know if another staff did a second check of the orders to ensure accuracy of the eMAR. -She expected orders to be entered into the eMAR accurately. -She expected medications to be administered as ordered.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a medication aide (MA) observed a resident taking their morning medications for 1 of 5 sampled residents (Resident #5). The findings are: Review of the current FL2 for Resident #5 dated 12/14/21 revealed diagnoses included:Alzheimer's dementia, major depression, atherosclerotic heart disease, atrial flutter, native	D 366		

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D 366	Continued From page 15 coronary artery without angina. Review of the electronic medication administration record (eMAR) notes for Resident #5 dated 03/12/22 at 3:37pm revealed: -Sat down medication for other resident to take, for a split second with head turned, resident (#5) took another residents medication. -Took vital signs and one hour after took another set of vitals. -On call nurse notified as well as responsible party and physician. -Physician advised not to send to emergency department and to hold morning medications. Review of the physician telephone orders for Resident #5 dated 03/12/22 revealed an order to take vitals in one hour and on the next shift, monitor for increased lethargy and increased falls. Review of the eMAR medications administered to the resident sitting with Resident #5 on 03/12/22 scheduled for 8:00am revealed: -Aspirin 81 mg (used to keep blood thinner)one tablet daily. -B12 (supplement to improve energy and memory) active chewable 1mg one tablet daily. -Depakote extended release (ER) 24 hour (used to treat seizures, bipolar disorder and dementia) 500mg one tablet daily. -Effexor XR capsule ER 24 hour 150mg 1 capsule daily (used to treat depression) -Effexor XR 24 hour 37. 5mg 1 capsule daily. -Folic Acid 1mg 1 tablet daily (used for certain types of anemia). -Vitamin D 2000 units once daily (used to maintain optimal blood levels) -Risperdal 0.5mg 1 tablet twice daily (used to treat dementia with behavioral disturbances).	D 366		

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D 366	Continued From page 16 Interview with a medication aide (MA) on 04/21/22 at 3:45pm revealed: -She was the MA for on the morning of 03/12/22. -She had given medication to the only resident sitting at the dining room table with Resident #5. -She had not given Resident #5 her morning medications. -She handed the resident sitting with Resident #5 the medication and water to take her medication and then left the dining room to give another resident their medication. -She had been called back to the dining room by another staff member who told her Resident #5 had taken medication that was not hers. -She thought the resident sitting with Resident #5 had spit out the medications and Resident #5 had picked them up and taken them. -She called the physician and the Health and Wellness Director (HWD). -She was not in the dining room at the time the Resident #5 took the medication as she had gone to give another resident their medications. -She verified the eMAR note on 03/12/22 was written by her. -She could not explain the discrepancy in the eMAR notes and what she had explained happened. -She explained what she had just conveyed was what actually happened. Telephone interview with a personal care aide (PCA) on 04/22/22 at 8:34am revealed: -She was working the morning of 03/12/21. -She was cleaning up the dining room after breakfast when she notice medication on a table. -There were two residents sitting at the table she identified as Resident #5 and another resident. -She took a picture of the medication on the table and then asked the two residents, "Whose	D 366		

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D 366	Continued From page 17	D 366		

medications are those?"
-Immediately Resident #5 picked up all the medication on the table and placed it in her mouth and began chewing them.
-She tried to get Resident #5 to spit out the medications but she could not get her to spit out the medications.
-It was all she could do to get a tiny piece of a brown pill off her lips where she had chewed them.
-The MA was not in the dining room at the time.
-She called the MA over the walkie talkie radio twice without a response.
-She then loudly yelled for the MA who entered the dining room.
-She explained to the MA what she had just observed and that Resident #5 had taken all the medication on the table.
-The medication did not appear wet to her when she observed the medication on the table.
-She confirmed the partial picture of a person at the top of the picture was not Resident #5 but the other resident who had been sitting at the table with Resident #5.

Observation on 04/22/22 at 8:40am of a photograph time stamped 03/12/22 at 7:47am revealed:
-There was a brown table cloth on the table.
-There was a plastic cup with approximately 1/2 cup of water was on the table.
-There was a plastic cup with approximately 1/4 cup of orange juice was on the table.
-There was a black plastic spoon was lying beside the cup of orange juice.
-There were seven pills lying on the table to the right of the spoon, a tiny white round pill, two small, round yellow pills, a small oval type brown pill, a small oval shaped white pill and a larger pink pill with "y95" on the tablet.

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D 366	Continued From page 18 -At the top of the picture there appeared to be a person in an orange shirt sitting at the table in front of the medication, cups and the spoon. Telephone interview with the Nurse Practioner (NP) on 04/22/22 at 9:40am revealed: -The facility had notified him Resident #5 had taken another residents medication. -He haed given orders for the facility to take Resident #5's vital signs then and then again in an hour. to monitor her and call him with any issues. -Resident #5 had no known liver issues, was not lethargic and did not appear to have any adverse symptoms to the incident. - He had followed up with the Resident #5 after the incident, he believed the following Tuesday. -Resident #5 was not allergic to any of the medications. -It would take 2-4 weeks for the Effexor to affect the Resident. -A one time dose of Depakote would not affect Resident #5's liver function unless she was already experiencing difficulties, which she was not. -The Risperdal could cause Resident #5 to be lethargic and he had asked the facility to monitor for this issue. -He had not ordered any labs as he did not feel they were necessary. Interview with the Administrator on 04/22/22 at 10:55am revealed: -It was her understanding the MA had put a cup of medications down on the medication cart or table and another resident picked them up when she turned away to help another resident. -The MA had spoken with the HWD and one of them called the primary care provider and the family and they had monitored the resident	D 366		

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D 366	Continued From page 19 throughout the shift. -The MA's are expected to watch the residents take their medications before leaving to give another resident their medications. -She thought the HWD would investigate what happened and talk with other staff but she did not know specifics. -The HWD was out of town and unable to be reached so she could not ask her. Attempted telephone interview with the HWD on 04/22/22 at 10:00am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.	D 366		