DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-060-085**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/20/22

NAME OF PROVIDER STREET ADDRESS, CITY, STATE, ZIP CODE

Brookdale South Park 5326 Park Road, Charlotte, NC 28209

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from October 19, 2022 to October 20, 2022.	D 000	Ted hose were ordered for resident #2 on 11/08/2022 and received on the evening of 11/08/2022. Family will provide ted hose moving forward per confirmation from resident #2 son.	11/08/22
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, record reviews and interviews, the facility failed to ensure documentation of treatment orders for 1 of 5 residents sampled (#2) related to compression stockings. The findings are: Review of Resident #2's FL-2 dated 05/06/22 revealed: -Diagnoses included dementia, type 2 diabetes, hypothyroidism, lower extremity edema, seizures, diverticulosis, and hyperlipidemia. -The resident required assistance with bathing and dressing. -The resident was constantly disoriented. -The resident was ambulatory. -There was an entry for compression stockings to be applied in the morning and removed at bedtime.	D 276	Education was provided to medicating staff regarding ordering supplies by the Resident Care Coordinator (RCC). No other resident was affected by this finding. Med cart audit will be conducted by night shift for any new orders and availability of medications and/ or supplies ordered nightly. Health and Wellness Director (HWD , RCC or designee will monitor daily for five (5) days, then weekly for three (3) weeks then periodically. Audits for medication/ supply availability plan of action will be discussed by the interdisciplinary team during QA as needed until resolved.	11/08/22 10/30/22

Tarrance Williams, ED 12/13/2022 Brookdale South Park Charlotte, NC
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Review of Resident #2's October 2022 electronic
PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE medication administration record (eMAR) revealed:
Reviewed and Acknowledged SCM 12/16/22

-There was an entry for compression stockings to be

applied at 7:00am. -

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There was documentation that compression stocking were applied at 7:00am from 10/01/22 to 10/10/22. -There was documentation to see progress notes

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D 276	Continued from page 1 Review of Resident #2's physician/healthcare provider order sheet dated 07/25/22 revealed there was an order to apply TED (thrombo-embolic deterrent) hose to the bilateral lower extremity (BLE) in the morning daily and remove it at bedtime. Observation of Resident #2 intermittently on 10/19/22 from 8:15am to 4:15pm and on 10/20/22 from 8:00am to 6:15pm revealed the resident was not wearing compression stockings. Review of Resident #2's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for compression stockings to be applied at 7:00am. There was documentation that compression stockings were applied at 7:00am from 10/01/22 to 10/10/22. -There was documentation to see progress notes regarding the application of compression stockings on 10/11/22, 10/13/22, and from 10/17/22 to 10/19/22. -There was a notation pharmacy action required regarding the application of compression stockings on 10/12/22, from 10/14/22 to 10/16/22. -There was an entry for compression stockings to be removed at 9:00pm. -There was documentation that compression stockings were removed at 9:00 pm on 10/01/22, 10/02/22, 10/10/22, 10/15/22 and 10/16/22. -There was documentation to see progress notes regarding the removal of compression stockings at 9:00 pm on 10/13/22.	D 276		

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D 276	Continued from page 2 -There was a notation that pharmacy action was required regarding the removal of compression stockings at 9:00pm from 10/03/22 to 10/09/22, 10/11/22, 10/12/22, 10/14/22, 10/17/22, and 10/18/22. Review of Resident #2's October 2022 progress notes revealed there was no documentation regarding compression stockings as mentioned on the eMAR at 7:00am on 10/11/22, 10/13/22, from 10/17/22 to 10/19/22 and at 9:00 pm on 10/13/22. Telephone interview with Resident #2's private pharmacy on 10/20/12 at 10:15am revealed they did not provide compression stockings. Telephone interview with the facility's contracted pharmacy on 10/20/22 at 12:25pm revealed: -The pharmacy department did not provide compression stockings. -The pharmacy's Senior Living Department provided compression stockings. -The facility would need to contact that department for compression stockings. Telephone interview with the facility's contracted pharmacy Senior Living Department on 10/20/22 at 12:26pm revealed: -One pair of compression stockings was last provided for Resident #2 on 04/07/22. -They had not received any subsequent orders for compression stockings for Resident #2 from the facility.	D 276		

Interview with medication aide (MA) on 10/20/22 at
PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE 2:45pm revealed:

_____

-She was told by the PCA that Resident #2 did not have
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any compression stockings a day or two ago.
-The resident received a pair of compression stockings about a month ago.
-She did not know what happened to the compression

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D 276	Continued from page 3 Interview with a personal care aide (PCA) on 10/20/22 at 2:40pm revealed: -Resident #2 had been without compression stocking for about 2-3 weeks. -The compression stockings that he had were too tight and caused some swelling to his legs. -She did not notify the Resident Care Coordinator (RCC) or the Executive Director (ED) that Resident #2 needed larger compression stockings because they were too tight. -She notified staff at the “stand-up” meeting at the beginning of the next shift that Resident #2’s compression stockings were too tight, and he needed another pair. Interview with medication aide (MA) on 10/20/22 at 2:45pm revealed: -She was notified by the PCA that Resident #2 did not have any compression stockings a day or two ago. -The resident received a pair of compression stockings about a month ago. -She did not know what happened to the compression stockings he received about a month ago. -She did not know how long a pair of compression stocking lasted before it was time to reorder them. -A notation in the eMAR that pharmacy action was required meant the medication or item was not available and had to be ordered from pharmacy. -She notified the RCC that Resident #2’s compression stockings needed to be ordered.	D 276		

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D 276	Continued from page 4 Interview with the RCC on 10/10/22 at 4:30pm revealed: -He faxed the order for compression stockings with measurements for Resident #2 on several occasions to the pharmacy. -The facility had not received the compression stockings as requested for Resident #2. -He sent the fax to the pharmacy department. -He was not aware there was a separate senior living department with a separate fax number at the pharmacy that provided the compression stockings. -Compression stockings should be available and implemented as ordered for Resident #2. Interview with the ED on 10/20/22 at 5:02pm revealed: -He was not aware that compression stockings were not available for Resident #2. -He expected Resident #2's compression stocking to be available and implemented as ordered. Interview with Resident #2' primary care provider (PCP) on 10/21/22 at 9:30am revealed: -There had been non-compliance in the past regarding Resident #2 wearing his compression stockings. -She expected Resident #2's compression stockings to be available and implemented as ordered for his healthcare needs.	D 276		

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D 276	Continued from page 5	D 276		
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 an 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, record reviews and interviews, the facility failed to ensure the administration of medications as ordered during the medication passes for 4 of 5 residents (#6, #7, #8, #9) as evidenced by errors with medications used to treat pain and high blood pressure (#6), medications used to treat ulcers, depression, and heartburn (#7), a medication used to treat anxiety (#8),	D 358	NP/ MD was made aware of the medication observations and gave no new orders for resident # 1,#2,#6,#7,#8 or #9. Health And Wellness Director (HWD) completed one to one education with identified medication with education focusing on the process for medication administration, ordering medication, medication not available, accurate documentation, late administration of medication and missed medication. Medication staff was educated on the process of reordering process medication to eliminate medications not being available by the Health And Wellness Director (HWD). Medication administration audits of medication technicians will be completed on a weekly basis by the Health And Wellness Director (HWD) or designee weekly for four (4) weeks then monthly for two (2) months, then periodically. Medication administration plan of action will be discussed by the interdisciplinary team during	10/21/22 10/21/22 10/21/22 10/30/22

			QA monthly until resolved.	

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D 358	Continued from page 6 a medication used to treat dementia (#9), and for 2 of 5 residents sampled (#1, #2) including medications used to treat fluid retention and a low potassium level in the body (#1), and medications used to treat constipation, depression, fluid retention, and urinary retention (#2). The findings are: 1. The medication error rate was 27% as evidenced by the observation of 8 errors out of 29 opportunities during the 8:00am and 9:00am medication passes on 10/19/22. a. Review of Resident #6's current FL-2 dated 08/27/22 revealed diagnoses included dementia, hypertension, hypothyroidism, and chronic back pain. Review of Resident #6's Resident Register dated 08/29/22 revealed an admission date of 09/02/22. Review of Resident #6's medication order report dated 09/15/22 revealed an order for Gabapentin 100mg, 1 capsule two times a day. (Gabapentin is a medication used to treat nerve pain). Observation of Resident #6's 9:00am medication pass on 10/19/22 revealed Gabapentin 100mg, 1 capsule was administered at 11:25am. Review of Resident #6's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Gabapentin 100mg, 1 capsule to be administered at 9:00am and 6:00pm. -There was documentation that Gabapentin 100mg, 1 capsule was administered for the 9:00am medication pass on 10/19/22.	D 358	QA as needed until resolved.	

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D 358	Continued from page 7 b. Review of Resident #6's medication order report dated 09/15/22 revealed an order for Quinapril HCl 40 mg, 1 tablet two times a day. (Quinapril is a medication used to treat high blood pressure). Observation of Resident #6's 9:00am medication pass on 10/19/22 revealed Quinapril HCL 40mg, 1 tablet was administered at 11:25am. Review of Resident #6's October 2022 eMAR revealed: -There was an entry for Quinapril HCl 40mg, 1 tablet two times a day for high blood pressure to be administered at 9:00am and 6:00pm. -There was documentation that Quinapril HCL 40mg, 1 tablet was administered for the 9:00am medication pass on 10/19/22. c. Review of Resident #6's medication order report dated 09/15/22 revealed an order for Tramadol HCl 50mg, 1 tablet four times a day. (Tramadol is used to treat moderate to severe pain). Observation of Resident #6's 8:00am medication pass on 10/19/22 revealed Tramadol HCL 50mg, 1 tablet was administered at 11:25am. Review of Resident #6's October 2022 eMAR revealed: -There was an entry for Tramadol HCL 50mg, 1 tablet to be administered at 8:00am, 12:00pm. 6:00pm and 10:00pm. -There was documentation that Tramadol HCL 50mg, 1 tablet was administered for the 8:00am medication pass on 10/19/22.	D 358		

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D 358	Continued from page 8 d. Review of Resident #7's current FL-2 dated 09/12/22 revealed diagnoses included dementia with agitation, depression, obsessive-compulsive disorder, gastro esophageal regurgitation disorder (GERD), hypothyroidism, irritable bowel syndrome with diarrhea predominance. Review of Resident #7's Resident Register revealed an admission date of 09/13/22. Review of Resident #7's medication order report dated 10/13/22 revealed there was an order for Carafate 1 gm, 1 tablet three times a day. (Carafate is a medication used to treat ulcers). Observation of Resident #7's 8:00am medication pass on 10/19/22 at 12:00pm revealed: -The medication aide (MA) popped the 8:00am and 12:00pm Carafate 1 gm (two tablets) out of the bubble card to administer two doses at 12:00pm on 10/19/22. -The MA was stopped from administering two doses of Carafate 1 gm by the surveyor. -Carafate 1 gm, 1 tablet was administered at 12:00pm on 10/19/22. Review of Resident #7's October 2022 eMAR revealed: -There was an entry for Carafate 1 gm 1 tablet to be administered at 8:00am, 12:00pm, and 4:00pm. -There was documentation that Carafate 1 gm, 1 tablet was administered for the 8:00am and 12:00pm medication pass on 10/19/22.	D 358		

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D 358	Continued from page 9 Interview with the medication aide (MA) on 10/19/22 at 12:00pm revealed: -She was going to give Carafate 1 gm (2 tablets) because the 8:00am dose had not been administered and it was time for the 12:00pm dose on 10/19/22. -She usually gave two doses of the medication when the administration of the first dose was late and close to the administration of the second one. Interview with the Resident Care Coordinator (RCC) on 10/20/22 at 4:30pm revealed he expected the correct medication dose to be administered for Resident #7. Interview with the Health and Wellness Director (HWD) on 10/20/22 at 4:05pm revealed: -She expected the correct medication dose to be administered as ordered for Resident #7. -The MA needed more medication administration training. Interview with the Executive Director (ED) on 10/20/22 at 5:02pm revealed: -He expected the correct medication dose to be administered as ordered for Resident #7. -The MA would undergo additional training on the administration of medications. Telephone interview with Resident #7's primary care provider (PCP) on 10/21/22 at 9:30am revealed: -Medications should be administered as ordered including dose and timeframe.	D 358		

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D 358	Continued from page 10 -It was concerning that the MA was going to administer two doses of the Carafate. -She would like to be notified when a medication was going to be administered late so she could provide direction on how to proceed. e. Review of Resident #7's medication order report dated 10/13/22 revealed there was an order for Trazodone HCL 50mg, three times a day. (Trazodone is a medication used for depression and a sleep aide). Observation of Resident #7's 9:00am medication pass on 10/19/22 revealed Trazadone HCL 50mg was administered at 12:00 pm on 10/19/22. Review of Resident #7's October 2022 eMAR revealed: -There was an entry for Trazodone HCL 50mg, 1 tablet three times a day at 8:00am, 2:00pm, and 8:00pm. -There was documentation that Trazodone HCL 50mg, 1 tablet was administered for the 8:00am medication pass on 10/19/22. f. Review of Resident #7's medication order report dated 10/13/22 revealed there was an order for Prilosec delayed release, 20mg, 1 tablet two times a day. (Prilosec is a medication used to treat heartburn). Observation of Resident #7's 8:00am and 9:00am medication pass on 10/19/22 revealed the Prilosec delayed release, 20mg, 1 tablet was administered at 12:00pm on 10/19/22. Review of the October 2022 eMAR revealed: -There was an entry for Prilosec 20mg, 1 tablet two times a day at 9:00am and 6:00pm. -There was documentation that Prilosec 20mg, 1 tablet was administered for the 9:00am medication pass on 10/19/22.	D 358		

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D 358	Continued from page 11 g. Review of Resident #8's FL-2 (no date) revealed diagnoses included Alzheimer's disease, amnesia, osteoarthritis, narcolepsy, osteopenia, and osteoporosis. Review of Resident #8's medication order report dated 09/23/22 revealed an order for Buspar HCL 7.5, 1 tablet two times daily. (Buspar is a medication used for anxiety). Observation of Resident #8's 9:00am medication pass on 10/19/22 revealed Buspar HCL 7.5 mg, 1 tablet was administered at 11:32am. Review of Resident #8's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Buspar HCL 7.5mg, 1 tablet two times a day at 9:00am and 6:00pm.-There was an entry for Buspar HCL 7.5mg, 1 tablet two times a day at 9:00am and 6:00pm. -There was documentation that Buspar HCL 7.5 mg, 1 tablet was administered for the 9:00am medication pass on 10/19/22. Refer to the interview with the MA on 10/20/22 at 2:45pm. Refer to the interview with the Health and Wellness Director (HWD) on 10/20/22 at 4:05pm. Refer to the interview with the RCC on 10/20/22 at 4:15pm. Refer to the interview with the ED on 10/20/22 at 5:02pm.	D 358		

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D 358	Continued from page 12 Refer to the interview with PCP on 10/21/22 at 9:30am. h. Review of Resident #9's current FL-2 dated 06/01/22 revealed diagnoses included dementia, hypertension, convulsions, hyperlipidemia, and acute pain. Review of Resident #9's Resident Register dated 05/25/22 revealed no admission date. Review of Resident #9's medication order report dated 07/12/22 revealed an order for Namenda XR 24-hour extended release, 28mg, 1 capsule once a day. (Namenda is a medication used to treat dementia). Observation of Resident #9's 9:00am medication pass on 10/19/22 revealed Namenda XR 24-hour extended release, 28mg, 1 capsule was not administered when she received her other medications at 11:45am on 10/19/22 because it was not available on the medication cart. Review of Resident #9's October electronic medication administration record (eMAR) revealed: -There was an entry for Namenda XR 24-hour extended release, 28mg, 1 capsule one time a day at 9:00am. -There was documentation that Namenda XR 24-hour extended release, 28mg, 1 capsule was not administered on 10/19/22 at 9:00am because it was not available on the medication cart and there was a notation that pharmacy action was required.	D 358		

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D 358	Continued from page 13 Telephone interview with the facility's contracted pharmacy on 10/20/22 at 10:15am revealed: -Resident #9's Namenda XR 24-hour extended release, 28mg was last dispensed on 08/07/22 for a 30-day supply. -The facility was not on a monthly auto-refill cycle. -The facility had to submit a medication refill request to the pharmacy when a medication needed to be refilled. -Based on dispensing history, the Namenda XR 24-hour extended release, 28mg should not have been available in the facility after 09/06/22. -The pharmacy received a refill request on yesterday 10/19/22 for Namenda XR 24-hour extended release, 28mg from the facility. -The pharmacy dispensed Namenda XR 24-hour extended release, 28mg on 10/19/22 for a 30-day supply. Interview with the MA on 10/20/22 at 2:45pm revealed: -The MA was responsible for ensuring medications were on the medication cart. -The MA could request a medication refill via the electronic medication administration record (eMAR) system or by faxing the request to the pharmacy. -The MA could also let the Resident Care Coordinator (RCC) know when a refill order was needed. -She did not know why the medication was not on the medication cart.	D 358		

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D 358	Continued from page 14 Interview with the RCC on 10/20/22 at 4:15pm revealed: -The MA could request a refill order for a medication from pharmacy. -Medication cart audits were conducted by third shift (11:00pm-7:00am). -Medications should be available on the medication cart for residents. Interview with the Executive Director (ED) on 10/20/22 at 5:02pm revealed he expected -He was not aware medications were not on the medication cart for the Resident #2. -He expected medications to be available on the medication cart. Telephone interview with Resident #9's PCP on 10/21/22 at 9:30am revealed: -She was not aware that medications were not on the medication cart for Resident #2. -She expected medications to be available on the medication cart and administered as ordered for the health and safety of the resident. Attempted telephone interview with Resident's 9's mental health provider on 10/20/22 at 11:30am was unsuccessful.	D 358		

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D 358	Continued from page 15 _____ Interview with the MA 10/20/22 at 2:45pm revealed: -The 8:00am and 9:00am medications were administered out of their time frame because she was the only MA on the 1st shift (7:00am to 3:00pm) to administer medications to 37 residents in the free-standing special care facility. -There was usually two MAs on the 1st shift. -The other MA had been on medical leave for about a week. Interview with the RCC on 10/20/22 at 4:15pm revealed: -There usually were two MAs on the 1st shift. -The other MA was out on leave since last week. -He expected medications to be administered as ordered including dose and timeframe. Interview with the HWD on 10/20/22 at 4:05 revealed: -She expected medications to be administered as ordered including dose and timeframe. -If a medication was going to be late, the PCP should be notified for instructions. Interview with the ED on 10/20/22 at 5:02 revealed he expected medications to be administered as ordered including dose and timeframe.	D 358		

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D 358	Continued from page 16 Interview with the PCP on 10/21/22 at 9:30am revealed: -She expected medications to be administered as ordered for the safety of the resident. -She would like to be notified when a medication was not going to be administered as ordered to give instructions on how to proceed. 2. Review of Resident #2's current FL-2 dated 05/06/22 revealed diagnoses included dementia, type 2 diabetes, hypothyroidism, lower extremity edema, seizures, and diverticulosis. a. Review of Resident#2's medication order dated 07/06/22 revealed there was an order for Senokot 5mg to be administered daily. (Senokot is a medication used for constipation). Review of October 2022 electronic medication administration eMAR) revealed: - There was an entry for Senokot S 8.6-50mg, 2 tablets at bedtime for constipation to be administered at 9:00pm. -There was documentation that Senokot S 8.6-50mg, 2 tablets were not administered because it required pharmacy action on 10/02/22, 10/07/22, 10/10/22, 10/11/22, and from 10/16/22 to 10/18/22. Observation of Resident #2's medication on hand on 10/20/22 at 10:00am revealed there was no Senokot 5mg on the medication cart.	D 385		

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-060-085**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/20/22

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D 358	Continued from page 17 Telephone interview with Resident #2's private pharmacy on 10/20/22 at 10:15am revealed Senokot 5mg was last dispensed on 08/25/22 for a 30-day supply. b. Review of Resident #2's medication order dated 07/06/22 revealed there was an order for Trazodone 150mg to be administered daily. (Trazodone is a medication used for depression and as a sleep aide). Review of Resident #2's August 2022 eMAR revealed: -There was an entry for Trazodone HCL 150mg, 1 tablet at bedtime to be administered at 9:00pm. -There was documentation that Trazodone was administered on 08/01/22, 08/06/22, 08/07/22, 08/10/22, 08/11/22, 08/24/22, 08/26/22, 08/27/22, 08/29/22, and 08/31/22. -There was documentation that Trazodone was not administered on 08/02/22, 08/03/22, 08/05/22, from 08/08/22, 08/09/22, from 08/12/22 to 08/23/22, 08/25/22, 08/28/22 08/30/22, because pharmacy action was required. Review of Resident #2's September 2022 eMAR revealed: -There was an entry for Trazodone HCL 150mg, 1 tablet at bedtime at 9:00pm. -There was documentation that Trazodone was administered on 09/03/22 and 09/26/22.	D 358		

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D 358	Continued from page 18 -There was documentation that Trazodone was not administered 09/01/22, 09/02/11, from 09/04/22 to 09/25/22, and from 09/27/22 to 09/30/22 because pharmacy action was required. Review of Resident #2's October 2022 eMAR revealed: -There was an entry for Trazodone HCL 150mg, 1 tablet at bedtime at 9:00pm. -There was documentation that Trazodone was administered on 10/05/22 and 10/15/22. -There was documentation that Trazodone was not administered from 10/01/22 to 10/04/22, from 10/06/22 to 10/08/22, 10/10/22, from 10/12/22 to 10/14/22, and from 10/16/22 to 10/18/22 because pharmacy action was required. Observation of Resident #2's medication on hand on 10/20/22 at 10:30am revealed there was no Trazodone 150mg on the medication cart. Telephone interview with Resident #2's private pharmacy on 10/20/22 at 10:15am revealed: Trazodone 150mg was last dispensed on 05/27/22 for a 30-day supply. c. Review of Resident #2's medication order dated 07/06/22 revealed there was an order for Lasix 20 mg to be administered two times a day (Lasix is a medication used for fluid retention or edema). Observation of Resident #2's medication on hand on 10/20/22 at 10:00am revealed there was no Lasix 20mg on the medication cart.	D 358		

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D 358	Continued from page 19 Telephone interview with Resident #2's private pharmacy on 10/20/22 at 10:15am revealed Lasix 20mg was last dispensed on 07/26/22 for a 30-day supply. Review of Resident #2's September 2022 eMAR revealed: -There was an entry for Lasix 20mg, 2 tablets at 8:00am and 1 tablet at 12:00pm. -There was documentation the 8:00am administration time was not administered from 09/01/22 to 09/30/22 because pharmacy action was required. -There was documentation the 12:00pm administration time was not administered from 09/01/22 to 09/30/22 because pharmacy action was required. Review of Resident #2's October 2022 eMAR revealed: -There was an entry for Lasix 20mg, 2 tablets at 8:00am and 1 tablet at 12:00pm. -There was documentation that Lasix 20mg, 2 tablets were not administered at 8:00am from 10/01/22 to 10/19/22 because pharmacy action was required. -There was documentation Lasix 20mg, 1 tablet was not administered at 12:00pm from 10/01/22 to 10/19/22 because pharmacy action was required. d. Review of Resident #2's medication order dated 07/06/22 revealed there was an order for Finasteride F/C 5mg to be administered daily. (Finasteride is a medication used to treat urinary retention). Observation of Resident #2's medication on hand on 10/20/22 at 10:00am revealed there was no Finasteride 5mg on the medication cart.	D 358		

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-060-085**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/20/22
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D 358	Continued from page 20 Review of #2's August 2022 eMAR revealed: -There was an entry for Finasteride F/C 5mg, 1 tablet one time a day to be administered at 8:30am. -There was documentation that Finasteride F/C 5 mg, 1 tablet was not administered from 08/02/22 to 08/31/22 because pharmacy action was required. Review of #2's September 2022 eMAR revealed: -There was an entry for Finasteride F/C 5mg, 1 tablet one time a day to be administered at 8:30am. -There was documentation that Finasteride F/C 5mg, 1 tablet was not administered from 09/01/22 to 09/30/22 because pharmacy action was required. Review of #2 October 2022 eMAR revealed: -There was an entry for Finasteride F/C 5mg, 1 tablet one time a day to be administered at 8:30am. -There was documentation that Finasteride F/C 5mg, 1 tablet was not administered from 10/01/22 to 10/19/22 because pharmacy action was required. Telephone interview Resident #2's private pharmacy on 10/20/22 at 10:15am revealed Finasteride 5 mg was last dispensed on 06/25/22 for a 30-day supply. Refer to interview with the medication aide (MA) on 10/20/22 at 2:45pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/20/22 at 4:14pm Refer to interview with the Executive Director (ED) on 10/20/22 at 5:02pm. Refer to interview with the primary care provider (PCP) on 10/21/22 at 9:30am.	D 358		

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FORM – DHSR LIMITED USE STATEMENT OF DEFICIENCIES

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D 358	Continued from page 21 _____ Interview with MA on 10/20/22 at 2:45pm revealed: -The MA was responsible for ensuring medications are on the medication cart. -The MA could request a medication refill via the electronic medication administration record (eMAR) system or by faxing the request to the pharmacy. -The MA could also let the RCC know when a refill order was needed. -She did not know why the medications were not on the medication cart. Interview with RCC on 10/20/22 at 4:15pm revealed: -The MA could request a refill order for a medication from pharmacy. -Medication cart audits are conducted by third shift (11:00pm-7:00am). -Medications should be available on the medication cart for residents. Interview with ED on 10/20/22 at 5:02pm revealed: -He was not aware medications were not on the medication cart for the residents. -He expected medications to be available on the medication cart. Telephone interview with PCP on 10/21/22 at 9:30am revealed: -She was not aware that medications were not on the medication cart for Resident #2. -She expected medications to be available on the medication cart and administered as ordered for the health and safety of the resident.	D 358		

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FORM – DHSR LIMITED USE STATEMENT OF DEFICIENCIES

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D 358	Continued from page 22 3. Review of Resident #1's current FL2 dated 08/19/22 revealed diagnoses of dementia, sleep disorder, neurocognitive disorder, 2 ethanol (ETOH) with behavioral disturbance, history of alcohol abuse, history of alcohol withdrawal seizure, history of melanoma-forearm, history of spinal fractures, and history of ductal carcinoma. a. Review of Resident #1's physician order dated 10/03/22 revealed there was an order for furosemide 20mg, 1 tablet daily for 7 days. (Furosemide is a medication used for fluid retention or edema). Review of Resident #1's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Furosemide 20mg, 1 tablet once daily to be administered at 9:00am. There was documentation of pharmacy action being required on 10/04/22 at 9:00am. -There was documentation that Furosemide 20mg, 1 tablet was not administered on 10/10/22 at 9:00am. -There was no documentation indicating the reason the Furosemide 20mg was not administered. -There was documentation of the Furosemide 20mg, 1 tablet not administered on 2 of 7 opportunities on 10/04/22 and 10/10/22. Observation of Resident #1's medications on hand on 10/20/22 at 3:32pm revealed: -There were 2 furosemide 20mg, tablets remaining in the bubble pack. -There was a bubble pack labeled furosemide 20mg, 1 tablet one time a day for fluid retention for 7 days.	D 358		

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D 358	Continued from page 23 b. Review of Resident #1's physician order dated 10/03/22 revealed there was an order for potassium chloride ER extended release 10meq, 1 tablet daily with food for 7 days. (Potassium chloride is a medication used to treat a low potassium level in the body). Review of Resident #1's October 2022 electronic eMAR revealed: -There was any entry for Potassium chloride 10meq once daily to be administered. -There was documentation of pharmacy review being required from 10/05/22 to 10/06/22. -There was documentation of the Potassium chloride ER 10meq, 1 tablet not administered on 10/10/22. -There was no documentation indicating the reason the medication was not administered. - There was documentation of the Potassium chloride 10meq, 1 tablet not administered on 3 of 7 opportunities on 10/04/22, 10/05/22, and 10/10/22. Observation of Resident #1's medications on hand on 10/20/22 at 3:32pm revealed: -There was a bubble pack labeled potassium chloride 10meq, 1 tablet daily for 7 days. -There were 3 potassium tablets remaining on the bubble pack. Interview with Medication Aide (MA) on 10/20/22 at 4:58pm revealed: -She was unaware Resident #1's medications had not been administered as ordered. -She worked the second shift, and the medications were ordered to be administered at 9:00am.	D 358		

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D 358	Continued from page 24 -The eMAR notes indicated the medications were not delivered on 10/04/22. -The Resident Care Coordinator (RCC) placed new medication orders from the pharmacy. -There was no record of furosemide oral tablet 20mg or potassium chloride 10meq being administered on 10/10/22 at 9:00am. Interview with RCC on 10/20/22 at 5:03pm revealed: -He was responsible for placing new medication orders from the pharmacy. -He did not locate documentation in the physician's order notes of placing orders for Resident #1's furosemide 20mg or potassium chloride 10meq. -He did not locate documentation in Resident #1's progress notes indicating who ordered Resident #1's furosemide oral tablet 20mg or potassium chloride ER tablet extended release 10meq. He believed there may have been a power outage on 10/10/22 resulting in there being no documentation on medication administration of Resident #1's furosemide oral 20mg or potassium chloride 10meq. -Staff were to document medication as administered on paper during power outages and transfer the information to the eMAR later. -He did not locate any documentation of Resident #1's furosemide 20mg or potassium chloride 10meq being administered.	D 358		

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D 366	Continue from page 25 10A NCAC 13F .1004 (j) Medication Administration 10 NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantify of medication administered; (4) Instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR) This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure electronic medication administration records (eMAR) were accurate for 1 of 5 residents (#9) observed during the medication pass; and 1 of 5 residents sampled (#2).	D 366	NP/MD made aware of medication observation for resident #1, #2 and #9 with no new orders given. A medication to cart audit was conducted by a registered nurse through collaborating facility pharmacy. MAR to cart audits will be conducted for new orders received and availability of medication and supplies by the night shift medication technician nightly. Monitoring will be completed on a weekly basis by the Health And Wellness Director (HWD) or designee weekly for four (4) weeks then monthly for two (2) months, then periodically. Audits for Medication Administration plan of action will be discussed by the interdisciplinary team during QA as needed until resolved.	10/21/22 10/26/22 10/30/22

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D 366	Continue from page 26 The findings are: 1. Review of Resident #2's current FL-2 dated 05/06/22 revealed diagnoses included dementia, type 2 diabetes, hypothyroidism, lower extremity edema, seizures, and diverticulosis. a. Review of Resident #2's medication order dated 07/06/22 revealed there was an order for Trazodone 150mg to be administered daily. (Trazodone is a medication used to treat depression and as a sleep aide). Telephone interview with Resident #2's private pharmacy on 10/20/22 at 10:15am revealed: -Trazodone 150mg was last dispensed on 05/27/22 for a 30-day supply. -The resident's Trazodone 150mg should not have been available in the facility after the 30-day supply ran out. Review of Resident #2's August 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Trazodone HCL 150mg, 1 tablet at bedtime at 9:00pm. -There was documentation that Trazodone was administered on 08/01/22, 08/06/22, 08/07/22, 08/10/22, 08/11/22, 08/24/22, 08/26/22, 08/27/22, 08/28/22, and 08/30/22. Review of Resident #2's September 2022 eMAR revealed: -There was an entry for Trazodone HCL 150mg, 1 tablet at bedtime to be administered at 9:00pm. -There was documentation that Trazodone was administered at 9:00pm on 09/03/22, 09/26/22 and on 09/19/22.	D 366		

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D 366	Continue from page 27 Review of Resident #2's October 2022 eMAR revealed: -There was an entry for Trazodone HCL 150mg, 1 tablet at bedtime to be administered at 9:00pm. -There was documentation that Trazodone was administered at 9:00pm on 10/05/22 and 10/15/22. b. Review of Resident #2's medication order dated 07/06/22 revealed there was an order for Senokot S 8.6-50mg to be administered daily. (Senokot is a medication used to treat constipation). Telephone interview with Resident #2's private pharmacy on 10/20/22 at 10:15am revealed: -Senokot S 8.6 50mg was last dispensed on 08/25/22 for a 30-day supply. -The resident's Senokot S 8.6 should not have been available in the facility after the 30-day supply ran out. Review of Resident #2's October 2022 eMAR revealed: -There was an entry for Senokot S 8.6-50mg, 2 tablets at bedtime for constipation. -There was documentation that Senokot S 8.6-50mg, 2 tablets were administered on 10/01/22, from 10/03/22 to 10/06/22, 10/08/22, 10/09/22, and 10/15/22. Refer to interview with the medication aide (MA) on 10/20/22 at 2:45pm. Refer to interview with the Resident Care Coordinator (RCC0 on 10/20/22 at 4:15pm. Refer to interview with the Executive Director (ED) on 10/20/22 at 5:02pm. Refer to interview with the primary care provider (PCP) on 10/21/22 at 9:30am.	D 366		

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-060-085**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/20/22

NAME OF PROVIDER STREET ADDRESS, CITY, STATE, ZIP CODE

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D 366	Continued from page 28 2. Review of Resident #9's current FL-2 dated 06/01/22 revealed diagnoses included dementia, hypertension, convulsions, hyperlipidemia, and acute pain. Review of Resident #9's Resident Register dated 05/25/22 revealed no admission date. Review of Resident #9's medication order report dated 07/12/22 revealed an order for Namenda XR 24-hour extended release, 28mg, 1 capsule once a day. (Namenda is a medication used to treat dementia. Telephone interview with the facility's contracted pharmacy on 10/20/22 at 10:15am revealed -Resident #9's Namenda XR 24-hour extended release, 28mg was last dispensed on 08/07/22 for a 30-day supply. -The resident's Namenda XR 24-hour extended release, 28mg should not have been available in the facility after 09/06/22. Review of Resident #9's September electronic medication administration record (eMAR) revealed: -There was an entry for Namenda XR, 24-hour extended release 28mg, 1 capsule one time a day at 9:00am -There was documentation Namenda XR, 24-hour extended release 28mg, 1 capsule was administered from 09/01/22 to 09/30/22, except 09/24/22 when resident was away from the facility. Review of Resident #9's October eMAR revealed: -There was an entry for Namenda XR 24-hour extended to be administered at 9:00am.	D 366		

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: **HAL-060-085**	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/20/22

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D 366	Continued from page 29 -There was documentation that Namenda XR 24-hour extended release, 28mg, 1 capsule was administered from 10/01/22 to 10/19/22 except 10/10/22, which was blank, and 10/19/22 which had the notation pharmacy action required because it was not available on the medication cart. Refer to interview with the medication aide (MA) on 10/20/22 at 2:45pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/20/22 at 4:15pm. Refer to interview with the Executive Director (ED) on 10/20/22 at 5:02pm. Refer to interview with primary care provider (PCP) on 10/21/22 at 9:30am. _____ Interview with the MA on 10/20/22 at 2:45pm revealed: -There were some MA's who would check off in the electronic system that a medication was given when it was not available on the medication cart. -If a medication was not available, the MA should document the reason the medication was not administered. Interview with the RCC on 10/20/22 at 4:15pm revealed: -Accurate documentation on the eMAR was important when a medication was not available on the medication cart. -He expected MAs to not document a medication as administered when the medication was not on the	D 366		

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D 366	Continue from page 30 medication cart. Interview with the ED on 10/20/22 at 5:02pm revealed he expected documentation of medication administration to be accurate. Interview with the PCP on 10/21/22 at 9:30am revealed: -She expected medication administration documentation to be accurate. -If the documentation in the eMAR was inaccurate, it could result in her making a medication change for a resident that was not needed.	D 366		

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Tarrance Williams, ED 12/13/2022 Brookdale South Park Charlotte, NC

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE