Received via electronic mail 07/19/23

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
	HAL076007	A. BUILDING _____ B. WING _____	R 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ASHEBORO	514 VISION DRIVE ASHEBORO, NC 27203

(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 and follow-up survey from 07/05/23 through 07/06/23.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#3 and #5) who had orders for a sleep aide (#3) and for a supplement (#5). The findings are: 1. Review of Resident #3's current FL2 dated 02/02/23 revealed: -Diagnoses included orthostatic hypotension, Parkinson's, anxiety disorder, and insomnia. -There was an order for trazodone (a sedative medication) 50mg take one-half tablet every night at bedtime. Review of Resident #3's physician order dated 06/02/23 revealed an order for trazodone 50mg take one-half tablet as needed if scheduled dose of trazodone 25mg is ineffective.	D 358	Health and Wellness Director will retrain Medication Aids on proper procedure for obtaining missing medications from the pharmacy as well as proper reporting procedure for missing medications. Health and Wellness Director or designee will review missed medication report daily for 4 weeks then weekly for 8 weeks then monthly for 2 months to ensure that proper procedures are being followed. Health and Wellness Director or designee will audit medication carts and MAR monthly to ensure ordered medications are present and MARs match current orders.	7/28/23 7/28/23 7/28/23

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 7/19/2023

Reviewed and acknowledged 07/19/23. SG

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D 358	Continued From page 1 Review of Resident #3's June 2023 electronic medication administration record (eMAR) revealed: -There was an entry for trazodone 50mg, take one-half tablet every night at bedtime scheduled at 8:00pm. -There was documentation trazodone was not administered from 06/16/23 through 06/25/23 due to "pharmacy action required." Review of Resident #3's Progress Notes for June 2023 revealed there was no documentation that the pharmacy had been contacted regarding needing a refill for Resident #3's trazodone. Observation of medication on hand for Resident #3 on 07/06/23 at 1:00pm revealed: -There was one medication card with trazodone 50mg half tablets take one half-tablet nightly as needed if initial dose of scheduled trazodone 25mg was not effective. -There was a dispensed date of 06/14/23 and 21 out of 30 dispensed half-tablets remaining. -There was no medication card for trazodone 50mg take one-half tablet scheduled every night at bedtime. Telephone interview with a representative from the facility's contracted pharmacy on 07/06/23 at 10:30am revealed: -The only trazodone order they had on file for Resident #3 was for trazodone 50mg take one-half tablet as needed at bedtime if initial scheduled dose was ineffective. -The pharmacy had received an electronic order on 12/22/22 to discontinue Resident #3's order for trazodone 50mg take one-half tablet scheduled every night at bedtime. -Trazodone 50mg as needed was last dispensed for Resident #3 on 06/15/23 for a 30-day supply	D 358		

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D 358	Continued From page 2 which was 30 half-tablets of trazodone 50mg. -Trazodone 50mg as needed was dispensed from a previous order dated 11/16/22 for Resident #3 on 01/11/23 for a 30-day supply which was 30 half-tablets of trazodone 50mg. -The last dispense date for Resident #3's scheduled trazodone 50mg, take one-half tablet every night at bedtime, was on 12/06/22 for 30 half-tablets. Interview with a medication aide (MA) on 07/05/23 at 4:00pm revealed: -She had worked the three days leading up to Resident #3's trazodone running out and had documented Resident #3's trazodone as not administered on 06/17/23 and 06/18/23, and 06/20/23 through 06/22/23. -She had not requested a refill of Resident #3's trazodone because it was a nightly scheduled medication and should be refilled automatically through the pharmacy's cycle-fill program. -Resident #3's trazodone required a new prescription with additional refills, so it was not automatically refilled and Resident #3 ran out. -She thought she had told the Director of Nursing (DON) that Resident #3's trazodone had not been refilled, but she could not remember. -Resident #3 never complained of poor sleep while he was out of trazodone. Interview with Resident #3 on 07/06/23 at 9:50am revealed: -He sometimes had restless sleep at night. -He was aware of the nights he was not administered trazodone. -He did not have a significant change in his sleep quality on the nights he did not take trazodone, but he would like to take it every night as ordered because it did help.	D 358		

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D 358	Continued From page 3 Interview with a second MA on 07/06/23 at 1:10pm revealed: -She always worked the day shift. -Resident #3 did sometimes say he had trouble sleeping during the night, but he never told her why. -She did not remember Resident #3 having any increased complaints of trouble sleeping from 06/16/23 through 06/25/23. -The MAs did not usually request refills from the pharmacy for medications that were on cycle fill because the pharmacy always sent the refill automatically every 30 days. -She did not know why Resident #3 would have run out of trazodone. Interview with Resident #3's power of attorney (POA) on 07/06/23 at 4:30pm revealed: -Resident #3 had mentioned to her in June 2023 that the facility had run out of his trazodone. -Resident #3 occasionally had trouble sleeping but she did not know if it was worse on the days he was out of trazodone. -The DON had told her that they ran out of Resident #3's trazodone because the needed a new prescription from his primary care provider (PCP). Interview with the DON on 07/06/23 at 3:15pm revealed: -Resident #3 ran out of trazodone because his prescription ran out of refills. -Resident #3's PCP had renewed the prescription for his as-needed trazodone, but forgot to renew the prescription for his scheduled trazodone. -The pharmacy filled Resident #3's as-needed trazodone, but they were still waiting on the order for his scheduled trazodone. -The MAs had been administering trazodone to Resident #3 from the as-needed medication card	D 358		

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D 358	Continued From page 4 because it was the same dose. -She was not aware that Resident #3 ran out of trazodone until Resident #3 told his family, and the family contacted her. -Resident #3 occasionally complained of having a restless night of sleep, and it was not worse in June 2023. -She completed medication cart audits, but only to check that all of the over-the-counter medications had labels on them; she did not check that all ordered medications were available on the cart. -The pharmacy had last completed a medication cart audit about two weeks prior and they checked for medications available as ordered, expiration dates, and that there were no discontinued medications on the cart, but they had not mentioned Resident #3 not having his scheduled dose of trazodone. Interview with the Administrator on 07/06/23 at 4:15pm revealed: -He was not aware Resident #3 had missed doses of trazodone from 06/16/23 through 06/25/23. -The MAs were expected to notify the DON if there was a medication that was not available for administration on the medication cart. -If the DON was aware of a medication not available; she would be expected to contact the resident's PCP and pharmacy to obtain the medication as soon as possible. -The staff never reported Resident #3 having trouble sleeping. -He expected all medications to be administered as they were ordered. Attempted telephone interview with Resident #3's PCP on 07/06/23 at 8:50am and 4:25pm were unsuccessful.	D 358		

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D 358	Continued From page 5 2. Review of Resident #5's current FL2 dated 05/12/23 revealed: -Diagnoses included Parkinson's, dementia, severe aortic stenosis, hypertension, atrial fibrillation, and atherosclerotic heart disease. -There was an order for coenzyme Q10 (an antioxidant supplement) 200mg daily. Review of Resident #5's May 2023 electronic medication administration record (eMAR) revealed: -There was an entry for coenzyme Q10 200mg daily scheduled at 9:30am. -There was documentation coenzyme Q10 was not administered on 05/25/23, 05/26/23, and 05/28/23 through 05/31/23 due to "pharmacy action required." Review of Resident #5's June 2023 eMAR revealed: -There was an entry for coenzyme Q10 200mg daily scheduled at 9:30am. -There was documentation coenzyme Q10 was not administered on 06/02/23, 06/03/23, 06/04/23, 06/06/23 or 06/08/23 due to "pharmacy action required." Observation of medication on hand for Resident #5 on 07/06/23 at 1:20pm revealed there was one medication card for coenzyme Q10 200mg with a dispensed date of 06/30/23 and 29 out of 30 dispensed tablets remaining. Telephone interview with a representative from the facility's contracted pharmacy on 07/06/23 at 10:30am revealed: -The pharmacy received a copy of Resident #5's FL2 on 05/24/23, but the facility did not request coenzyme Q10 be dispensed at that time.	D 358		

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D 358	Continued From page 6 -The pharmacy received a refill request for Resident #5's coenzyme Q10 on 06/08/23 and a 28-day supply was dispensed that day, on 06/08/23. -On 06/30/23, the pharmacy dispensed 30 tablets of coenzyme Q10 for Resident #5. Interview with a medication aide (MA) on 07/06/23 at 1:10pm revealed: -When Resident #5 was admitted to the facility he came with his medications in bottles from the pharmacy he used while living at home, so refills were not needed initially. -She had not requested a refill for Resident #5's coenzyme Q10 because she thought the resident had an over-the-counter bottle of it from home. -She could not remember if she had let the Director of Nursing (DON) know that Resident #5 did not have coenzyme Q10 available to administer. -She did not know why Resident #5's coenzyme Q10 was not administered between the dates of 05/25/23 and 06/08/23 because if a medication was requested from the pharmacy it usually arrived the following day. Interview with the DON on 07/06/23 at 3:15pm revealed: -Resident #5 was admitted to the facility at the end of May 2023 from home. -Resident #5 brought his medication bottles from home when he was admitted to the facility. -Coenzyme Q10 was listed as a current medication order on Resident #5's FL2, but he did not have any coenzyme Q10 with him upon admission to the facility. -Usually, when she faxed a new resident's FL2 to the pharmacy they dispensed the medication to the facility within one day's time. -She was not aware Resident #5 had missed	D 358		

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D 358	Continued From page 7 doses of coenzyme Q10. -The MAs were expected to call the facility's contracted pharmacy if a medication was not available on the medication cart to administer. Telephone interview with Resident #5's primary care provider (PCP) on 07/06/23 at 3:30pm revealed: -Resident #5 was ordered coenzyme Q10 as a supplement to help him regain energy. -She was aware Resident #5 had missed 11 doses of coenzyme Q10 after he was admitted to the facility because someone at the facility had contacted her to send a new prescription to the pharmacy. -There would be no adverse effects for missing doses of coenzyme Q10, but she expected the facility staff to ensure all ordered medications were available and administered as ordered. Interview with the Administrator on 07/06/23 at 4:15pm revealed: -He was not aware Resident #5 had missed doses of coenzyme Q10. -The MAs were expected to notify the DON if there was a medication that was not available for administration on the medication cart. -If the DON was aware of a medication not available, she would be expected to contact the resident's PCP and pharmacy to obtain the medication as soon as possible. -He expected all medications to be administered as they were ordered. Based on observation, record review and interview, it was determined Resident #5 was not interviewable.	D 358		