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	HAL049021	A. BUILDING: _____ B. WING _____	03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PEACHTREE MC	2814 PEACHTREE ROAD STATESVILLE, NC 28625

(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 a follow-up survey on March 13, 2017 and March 14, 2017.	D 000		
D 235	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure each resident had an annual medical exam recorded on a current FL-2 for 2 of 5 sampled residents (Resident #1 and #3). The findings are: A. Review of Resident #1's most current FL-2 dated 02/02/16 revealed diagnoses included Alzheimer disease and hip fracture. Review of Resident #1's record revealed there was no current annual medical exam (FL-2) in the record for review. Interview on 03/13/17 at 12:20 pm with Resident	D 235		

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#1's hospice nurse revealed:
-Resident #1 had been on hospice services for about 6 months.
-The hospice Medical Director was responsible for completing the annual medical exam (FL-2) for Resident #1.
-The nurse was unaware the FL-2 for Resident #1 was outdated.
-The nurse was aware FL-2 were to be completed yearly for Resident #1.
-She would immediately contact the hospice Medical Director and obtain a completed FL-2 for Resident #1.

Review on 03/14/17 of Resident #1's record revealed a current FL-2 dated 03/13/17.

Refer to interview on 2:10 pm with the Health and Wellness Director (HWD).

Refer to telephone interview on 03/13/17 at 7:10 pm with the Resident Care Coordinator (RCC).

Refer to interview on 03/13/17 at 3:00 pm with the Executive Director (ED).

B. Review of Resident #3's most current FL-2 dated 11/18/14 revealed diagnoses that included dementia and hypertension .

Review of Resident #3's record revealed there was no current annual medical exam (FL-2) in the record for review.

Review on 03/14/17 of Resident #3's record revealed a current FL-2 dated 03/13/17.

Refer to interview on 2:10 pm with the HWD.

Refer to telephone interview on 03/13/17 at 7:10

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D 235	Continued From page 2 pm with the RCC. Refer to interview on 03/13/17 at 3:00 pm with the ED. _____ Interview on 2:10 pm with the HWD revealed: -She had been employed as the HWD for about 18 months. -She and the RCC were responsible for reviewing resident's records, and updating the FL-2 when needed. -She made a tracking form for all residents which included the FL-2's and when they were to be completed annually by the physician. -She was unaware the FL-2's for Resident #1 and #3 were outdated. -She missed several months at work and felt the FL-2's had "gotten over looked". -The RCC was new to the facility and probably was not aware the FL-2 were outdated for Resident #1 and #3. -She would immediately obtain current FL-2's for both Resident #1 and #3. Telephone interview on 03/13/17 at 7:10 pm with the RCC revealed: -She had worked in the facility as the RCC for 2 months. -She was new to the position and was still learning her role as RCC. -She was aware the FL-2's were to be completed by the physician annual for all residents. -She was unaware the FL-2's for Resident #1 and #3 were outdated. -She was aware of the tracking form in the HWD's office, but had not looked over the tracking form to identify the outdated FL-2's for the residents.	D 235		

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D 235	Continued From page 3 Interview on 03/13/17 at 3:00 pm with the ED revealed: -She relied on the RCC and the HWD to oversee resident's record for compliance. -She was unaware the FL-2's were outdated for Resident #1 and #3. -She was aware the FL-2's were to be completed yearly by the physician. -She would immediately have the HWD obtain current FL-2's for both Resident #1 and #3.	D 235		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure proper infection control measures were used for 5 of 5 residents (Resident # 6, #7, #1, #8, and #9) observed during the morning medication pass. The findings are: Review of the facility policy for medication and treatments included, associates will wash their hands or use hand sanitizer prior to administering medications to the residents, and tablets should not be poured into the associates hands or touched during the medication pass.	D 371		

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D 371	Continued From page 4 Observation on 03/14/17 between 8:15 am and 8:58 am during the morning medication pass revealed the Medication Aide (MA) administered medications to the residents while the residents were eating breakfast in the dining room area. A. Review of Resident #6's current FL-2 dated 12/28/16 revealed diagnoses included Alzheimer disease. Observation of the MA between 8:15 am and 8:20 am revealed: -The MA did not wash her hands, or use hand sanitizer prior to administering medications to Resident #6. -The MA opened the medication cart and removed 2 pharmacy generated punch cards labeled with Resident #6's name out of the drawer. -The MA placed the punch cards on the top of the medication cart. -The MA popped one tablet out of each punch card into a souffle cup. -The MA placed the punch cards back into the medication cart drawer. -The MA went into the dining room area and placed her left hand on Resident #6's shoulder and gave Resident #2 the souffle cup. -The MA stayed with Resident #6 until the 2 tablets were administered. -Resident #6 gave the empty souffle cup to the MA. -The MA returned to the cart and placed the souffle cup into the trash. -The MA documented on the electronic medications administration record (eMAR) 2 medications had been administered to Resident #6. -The MA did not wash her hands, or use hand	D 371		

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sanitizer after administering medications to Resident #6.

Refer to the interview on 03/14/17 at 10:50 am with the Health and Wellness Director (HWD).

Refer to the interview on 03/14/17 at 11:15 am with the morning MA.

Refer to the interview on 03/14/17 at 11:25 am with the Executive Director (ED).

B. Review of Resident #7's current FL-2 dated 10/05/16 revealed diagnoses included Alzheimer disease.

Observation of the MA between 8:21 am and 8:25 am revealed:
-The MA did not wash her hands, or use hand sanitizer prior to administering medications to Resident #7.
-The MA opened the medication cart and removed 3 pharmacy generated punch cards labeled with Resident #7's name out of the drawer.
-The MA placed the punch cards on the top of the medication cart.
-The MA popped one tablet out of each punch card into a souffle cup.
-The MA crushed the 3 tablets and mixed with yogurt into the souffle cup.
-The MA placed the 3 punch cards back into the medication cart drawer.
-The MA went into the dining room area and placed her right hand on the back of Resident #7's chair and squatted down to be on eye level with Resident #7.
-The MA administered the crushed medications mixed with yogurt to Resident #7.
-The MA returned to the cart and placed the

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souffle cup into the trash.
-The MA documented on the electronic medications administration record (eMAR) 3 medications had been administered to Resident #7.
-The MA used hand sanitizer after administering medications to Resident #7.

Refer to the interview on 03/14/17 at 10:50 am with the HWD.

Refer to the interview on 03/14/17 at 11:15 am with the morning MA.

Refer to the interview on 03/14/17 at 11:25 am with the ED.

C. Review of Resident #1's current FL-2 dated 03/13/17 revealed diagnoses included Alzheimer disease.

Observation of the MA between 8:26 am and 8:33 am revealed:
-The MA opened the medication cart and removed 3 pharmacy generated punch cards labeled with Resident #1's name out of the drawer.
-The MA popped 2 tablets and 2 capsules in a souffle cup.
-The MA crushed the 2 tablets and placed them into a souffle cup.
-The MA opened two the capsules using her hands, and dumped the medication into the souffle cup which contained the 2 crushed tablets.
-The MA mixed all the medications with yogurt.
-The MA placed the 3 punch cards back into the medication cart drawer.
-The MA went into the dining room area and administered the crushed medications mixed with

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yogurt to Resident #1.
-The MA walled into the activity room after administering the medications to Resident #1 holding the empty souffle cup, and obtained a walker for another residents who was leaving the dining room area.
-The MA then returned to the cart and placed the souffle cup into the trash.
-The MA documented on the eMAR 3 medications had been administered to Resident #1.
-The MA did not wash her hands, or use hand sanitizer after administering medications to Resident #1.

Refer to the interview on 03/14/17 at 10:50 am with the HWD.

Refer to the interview on 03/14/17 at 11:15 am with the morning MA.

Refer to the interview on 03/14/17 at 11:25 am with the ED.

D. Review of Resident #8's current FL-2 dated 02/13/17 revealed diagnoses included Alzheimer disease.

Observation of the MA between 8:35 am and 8:40 am revealed:
-The MA did not wash her hands, or use hand sanitizer prior to administering medications to Resident #8.
-The MA opened the medication cart and removed 7 pharmacy generated punch cards labeled with Resident #8's name out of the drawer.
-The MA placed all 7 punch cards on the medication cart.
-The MA popped 3 tablets into a souffle cup, the

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fourth tablet landed on the top of the medication cart.
-The MA picked the tablet off the top of the medication cart and placed the tablet into the souffle cup using her right hand.
-The MA continued to pop the remaining 3 tablet into the souffle cup.
-The MA placed the 7 punch cards back into the medication cart drawer.
-The MA went into the dining room area and handed the souffle cup to Resident #8.
-Resident #8 took one tablet out of the souffle cup and swallowed each tablet separate, the MA stood directly beside her until she had completed all the medications.
-The MA then returned to the cart and placed the souffle cup into the trash.
-The MA documented on the eMAR 7 medications had been administered to Resident #8.
-The MA did not wash her hands, or use hand sanitizer after administering medications to Resident #8.

Refer to the interview on 03/14/17 at 10:50 am with the HWD.

Refer to the interview on 03/14/17 at 11:15 am with the morning MA.

Refer to the interview on 03/14/17 at 11:25 am with the ED.

E. Review of Resident #9's current FL-2 dated 12/30/16 revealed diagnoses included Alzheimer disease.

Observation of the MA between 8:44 am and 8:58 am revealed:
-The MA did not wash her hands, or use hand

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D 371	Continued From page 9 sanitizer prior to administering medications to Resident #9. -The MA opened the medication cart and removed 8 pharmacy generated punch cards labeled with Resident #9's name out of the drawer. -The MA placed all 8 punch cards on the top of the medication cart. -The MA popped 5 tablets into a souffle cup, the sixth and seventh tablets landed on the top of the medication cart. -The MA picked both tablets off the medication cart and placed the tablets into the souffle cup, using her right hand. -The MA continued to pop the remaining tablet into the souffle cup. -The MA crushed the tablets and mixed the medications with yogurt in a souffle cup. -The MA placed the 8 punch cards back into the medication cart drawer. -The MA removed a container of Miralax for Resident #9 and mixed the appropriate amount with water and stirred until dissolved. -The MA used hand sanitizer. -The MA went into the dining room area and placed her right hand on the back of Resident #9's chair and squatted down to be on eye level with Resident #9. -The MA administered the crushed medications mixed with yogurt to Resident #9 as well as the Miralax and water. -The MA returned to the cart and placed the souffle cup and the water cup into the trash. -The MA documented on the eMAR, 9 medications had been administered to Resident #9. Refer to the interview on 03/14/17 at 10:50 am with the HWD.	D 371		

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D 371	Continued From page 10 Refer to the interview on 03/14/17 at 11:15 am with the morning MA. Refer to the interview on 03/14/17 at 11:25 am with the ED. Interview on 03/14/17 at 10:50 am with the Health and Wellness Director (HWD) revealed: -The guidelines for medications administration were to wash hands after the 3rd resident medication pass, and to use hand sanitizer prior to administering medications to residents. -If a medication dropped on the floor or anywhere else it should be destroyed, and documented in the eMAR system. -The medication carts should be wiped down daily on 3rd shift, and should be cleaned weekly. -The MAs, prior to being placed alone on the medication carts, are scheduled with a nurse for mandatory infection control training for 2 days. -The new MAs shadow a MA for 3 days on the medication cart, and then the MA shadows her for a total of 6 days of training on the medications cart. Interview on 03/14/17 at 11:15 am with the morning MA revealed: -She was a MA for about 3 months. -She was not aware if a tablet/pill dropped on the top of the medication cart she could not pick it up. -No one at the facility told her she could or could not pick up a tablet/pill off the top of the medication cart and administer to a resident. -She was aware if a tablet/pill dropped on the floor it was to be destroyed, and then documented on the eMAR. -She was aware hand sanitizer was to be used prior to administering medications to the residents, "I guess I forgot." -She stated "I clean the cart after my shift."	D 371		

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D 371	Continued From page 11 Interview on 03/14/17 at 11:25 am with the Executive Director revealed: -She relied on the HWD and the Resident Care Coordinator to oversee the clinical nursing staff. -She was familiar with the morning MA and had seen her administering medications to the residents. -The MA had always popped the medications into the souffle cups when she had observed her. -She was unaware the MA had not used hand sanitizer, washed her hands, or picked up the tablets off the top of the medication cart and administered the medications to the residents. -She would ask the HWD to conduct an in-service on infection control training for all MA.	D 371		