PRINTED: 06/09/2017 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		HAL034035	B. WING		0.5	5/24/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
BROOKD	ALE REYNOLDA ROAD		YNOLDA ROAD	0.0		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ON SALEM, NC 2710	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 000	Initial Comments		D 000			
	The Adult Care Licenary	sure Section conducted an y 23-24, 2017.				
D 358	10A NCAC 13F .1004 Administration	(a) Medication	D 358			
	(a) An adult care hor preparation and admi prescription and nonby staff are in accordance (1) orders by a licens which are maintained	Medication Administration me shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies				
	reviews, the facility fa administered Humalo insulin used to lower	ns, interviews, and record iiled to assure staff g (Humalog is rapid-acting elevated blood sugar levels) sed prescribing practitioner				
	The findings are:					
	11/17/16 revealed: -Diagnoses included dizziness and giddine gait and mobility, other type II diabetes with a complication.	orthostatic hypotension, ess, other abnormalities of er lack of coordination, and other neurological				
	dated 12/01/16 for Hu					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEPOCENCIES AND FLAN OF CORRECTION INTERPRETATION NUMBER: HALD34035 NAME OF PROVIDER OR SUPPLIER BROOKDALE REYNOLDA ROAD WINSTON SALEM, NC 27106 PROVIDER (SCALED STATES OF THE SELECTION OF THE STATE OF THE SELECTION OF THE SE	DIVISION	of Health Service Regu	lation					
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STATE FORM 6899 HYHF11 If continuation sheet 2 of 7

Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL034035	B. WING		05/24/2017		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
222212		2980 REY	NOLDA ROAD				
BROOKD	ALE REYNOLDA ROAD	WINSTON	SALEM, NC 2	7106			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE		
D 358	Continued From page	2	D 358				
	for April 2017.	apportunities where					
	-There were 14 of 15	opportunities where ild have been administered					
	as follows:	na nave been aanmineterea					
		pm FSBS result was 268.					
	No documentation of units.	administration of Humalog 8					
		pm FSBS result was 290.					
		administration of Humalog 8					
	units.						
		pm FSBS result was 268.					
	units.	administration of Humalog 8					
		pm FSBS result was 278.					
	No documentation of units.	administration of Humalog 8					
		pm FSBS result was 262.					
	units.	administration of Humalog 8					
		pm FSBS result was 283. administration of Humalog 8					
		pm FSBS result was 292. administration of Humalog 8					
		pm FSBS result was 371. ninistration of Humalog 8					
	units.	Tillistration of Flumalog o					
	-On 04/15/17 at 5:00	pm FSBS result was 325. administration of Humalog 8					
	units.						
	No documentation of	pm FSBS result was 280. administration of Humalog 8					
	units. -On 04/18/17 at 5:00	pm FSBS result was 257.					
No documentation of administration of Humalog 8							

-On 04/20/17 at 5:00 pm FSBS result was 291. No documentation of administration of Humalog 8

STATE FORM 6899 HYHF11 If continuation sheet 3 of 7

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL034035	B. WING		05/24/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
BBOOKD.	ALE REYNOLDA ROAD	2980 REYI	NOLDA ROAD			
BROOKD	ALL KLINOLDA KOAD	WINSTON	SALEM, NC 2	7106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLE	
D 358	Continued From page	3	D 358			
	-On 04/24/17 at 5:00 No documentation of units. -On 04/28/17 at 5:00 No documentation of units. -On 04/29/17 at 5:00	pm FSBS result was 274. administration of Humalog 8 pm FSBS result was 280. administration of Humalog 8 pm FSBS result was 314. administration of Humalog 8				
	revealed: -There was an entry f sugar) at 7:00 am and -There was an entry f units as needed if blo 250The resident's blood for May 2017There were 9 of 9 op 8 units should have b -On 05/01/17 at 5:00 No documentation of units.	or FSBS (fingerstick blood				
	No documentation of unitsOn 05/07/17 at 5:00 No documentation of unitsOn 05/09/17 at 5:00 No documentation of unitsOn 05/13/17 at 5:00 No documentation of unitsOn 05/14/17 at 5:00	administration of Humalog 8 pm FSBS result was 283. administration of Humalog 8 pm FSBS result was 294. administration of Humalog 8 pm FSBS result was 255. administration of Humalog 8 pm FSBS result was 253. administration of Humalog 8				

Division of Health Service Regulation

-On 05/18/17 at 5:00 pm FSBS result was 285.

STATE FORM 6899 HYHF11 If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		l \ /	(X3) DATE SURVEY COMPLETED	
		HAL034035	B. WING		05	/24/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE	•	-
BBOOKD	ALE REYNOLDA ROAD	2980 REY	NOLDA ROAD			
BROOKD	ALE RETNOLDA ROAD	WINSTO	N SALEM, NC 271	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 358	Continued From page	: 4	D 358			
	unitsOn 05/20/17 at 5:00 No documentation of unitsOn 05/22/17 at 5:00 No documentation of units. Observation of medic at 12:10 pm revealed for administration. Interview with the first on 05/24/17 at 12:20 -She was not aware of units as needed for Figure 15:00	administration of Humalog 8 pm FSBS result was 285. administration of Humalog 8 pm FSBS result was 254. administration of Humalog 8 ations on hand at 05/24/17 Humalog was not available shift Medication Aide (MA) pm revealed: of the order for Humalog 8 SBS greater than 250. had never been over 200				
	(HWD) and Executive at 12:30 pm revealed -The HWD and ED de Humalog not being gi -The HWD and ED de Humalog was not ava -The HWD, ED, and Medications into the elements of the Humalog with the phy 05/24/17 at 12:50 pm -The PA was not awareceiving the Humalog greater than 250. -The facility had not not not not not not been receiving -The PA did not feel F	enied knowledge of the ven as ordered. enied knowledge that the ilable for administration. MA's entered the eMAR system. esician assistant (PA) on revealed: re Resident #1 had not been g as needed for FSBS				

Division of Health Service Regulation

STATE FORM 6899 HYHF11 If continuation sheet 5 of 7

DIVISION	n nealth Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED
, and a 2 are of the contract		IDENTIFICATION NOMBER.	A. BUILDING: _		COMI LETED
			5		
		HAL034035	B. WING		05/24/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
BBOOKD	N E DEVNOI DA DOAD	2980 REY	NOLDA ROAD		
BROOKDA	ALE REYNOLDA ROAD	WINSTON	SALEM, NC 2	7106	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	÷ 5	D 358		
	FSBS greater than 25	50.			
		f Resident #1's blood sugar			
		ility's contracted pharmacy			
	on 05/24/17 at 1:00 p				
		red the order 12/03/16, but uest prn medications to be			
	sent to the facility.				
	-The facility called and faxed the contracted				
	pharmacy on 05/24/17 to request Humalog to be				
	sent immediatelyThe pharmacy had no record of the Humalog				
	ever being filled.	o record of the Humalog			
	Interview with the second shift MA on 05/24/17 at 2:45 pm revealed:				
		e order for Humalog 8 units			
	as needed for FSBS				
	for FSBS greater than	d the Humalog in the past n 250.			
		n days she administered the			
	•	o document on the eMAR.			
	 She was unable to re administered Humalo 				
	administered numaio	g to Resident #1.			
	Interview with Reside	nt #1 on 05/24/17 at 3:25			
	pm revealed:				
	 Resident #1 was not insulins the staff admi 	aware of the different			
	mount the otal dam	t aware of the amount of			
	insulin he received or	a daily basis or as needed.			
		d 2-3 insulin injections every			
	day.				
	Interview with another	r second shift MA on			
	05/24/17 at 3:45 pm r				
	-Resident #1 had Hur	nalog available for			
administration at one time, but the Humalog had					

Division of Health Service Regulation

not been available recently.

STATE FORM 6899 HYHF11 If continuation sheet 6 of 7

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
		HAL034035	B. WING		05	/24/2017
	ROVIDER OR SUPPLIER ALE REYNOLDA ROAD	2980 RE	DDRESS, CITY, STA YNOLDA ROAD N SALEM, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 358	-She was unaware of been unavailable for a -She sent the contract requesting Humalog, the fax confirmationShe was unable to consent to the contracted	how long the Humalog had administration. ted pharmacy a fax but was unable to produce onfirm when the fax was I pharmacy.	D 358			

Division of Health Service Regulation

STATE FORM 6899 HYHF11 If continuation sheet 7 of 7