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
	HAL034026	A. BUILDING: _____ B. WING _____	R 05/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF WINSTON SALEM	2601 REYNOLDA ROAD WINSTON SALEM, NC 27106

(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 Forsyth County Department of Social Services conducted a follow-up survey on May 30-31, 2017.	{D 000}	Please see attached Plan of Correction	
{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: FOLLOW-UP TO Type B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 7 sampled residents (Resident #5), regarding metoprolol succinate 25mg ER and metoprolol tartrate 25mg. The findings are: Review of Resident #5's current FL2 dated 5/09/17 revealed: -Diagnoses included dementia and cognitive impairment. -A physician's order for metoprolol succinate	{D 358}		

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{D 358}	Continued From page 1 25mg ER daily (a long acting medication used to treat high blood pressure [BP]) and metoprolol tartrate 25mg (a short acting medication used to treat high BP) take 1 tablet daily at 9:00 am if systolic blood pressure (SBP) is greater than 150. Review of Resident #5's record with signed physician's orders dated 2/28/17 revealed: -An order for metoprolol succinate 25mg ER daily. -An entry to check blood pressure (BP) every day at 9:00 am. -An order for metoprolol tartrate 25mg take 1 daily at 9:00 am if SBP was greater than 150. -A diagnosis of hypertension (high blood pressure),which was not included on the current FL2 dated 5/09/17. Review of Resident #5's March 2017, April 2017 and May 2017 electronic Medication Administration Record (eMAR) revealed: -An entry for metoprolol succinate 25mg ER was documented as administered daily at 9:00 am from 3/01/17 to 5/29/17. Documentation on the back of the eMar revealed Resident #5 refused metoprolol succinate 25mg on 5/30/17. -There was no entry for BP checks to be obtained daily at 9:00 am and no BP results were documented from 3/01/17 to 5/30/17. -An entry for metoprolol tartrate 25mg daily at 9:00 am if SBP was greater than 150 with no documented administrations of BP from 3/01/17 to 5/30/17. Review of Resident #5's progress notes on 5/31/17 revealed monthly rather than daily BP checks were obtained in March 2017, April 2017 and May 2017 and ranged from 128/70 to 140/64. Interviews on 5/30/17 at 3:00 pm and 5/31/17 at	{D 358}		

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{D 358}	Continued From page 2 11:56 am with the Resident Care Director (RCD) revealed: -The facility had converted from using paper MARs to eMARs on 2/21/17. -The RCD and the Wellness Nurses were responsible for comparing the eMARs to the paper MARs for accuracy when the facility converted from paper to electronic MARs on 2/21/17. -The RCD and the Wellness Nurses were responsible for transferring BP orders from the February paper MAR to the March eMAR. The order for BP checks daily was omitted from the March eMAR. Observation on 5/30/17 at 4:35 pm of medications on hand for Resident #5 revealed: -There was no metoprolol succinate 25mg ER on the medication cart. -A bingo card of metroprolol tartrate 25mg labeled take daily at 9:00 am if SBP was greater than 150 with a quantity of 15 dispensed on 5/08/17 with 8 tablets remaining. Interview on 5/30/17 at 4:35 pm with the evening shift Medication Aide (MA) revealed: -The MAs were responsible for administering medications as ordered. -MA staff were trained to notify the pharmacy if any medication was out of stock and the pharmacy would deliver the medication that day or the following day depending on time of order. -Resident #5 did not have any metoprolol succinate 25mg ER on the medication cart but metoprolol tartrate 25mg "is the same thing", as metroprolol succinate 25mg ER. -She was not aware that metoprolol succinate 25mg ER and metoprolol tartrate 25mg were different medications that could not be used interchangeably.	{D 358}		

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{D 358}	Continued From page 3 Interview on 5/30/17 at 5:25 pm with a second MA revealed: -If a resident had an order for BP to be checked, the task would populate in the eMAR to alert the MA to perform it. -If a task was not scheduled for that particular shift, the MA would not see it. -MAs were not allowed to enter orders into the eMAR. -The RCD and the Wellness Nurses were responsible for entering orders into the eMar. Interview on 5/31/17 at 9:42 am with Resident #5 revealed: -She was unaware if or how often the staff checked her BP. -MAs administered her medications but she was not aware of which medications were administered to her. -She expected the MAs to give her any medications ordered by her physician. Interview on 5/31/17 at 9:59 am with the morning shift MA revealed: -The MAs had checked Resident #5's BP at one time but had not done so recently. -Resident #5 did not have any metoprolol succinate 25mg ER on the medication cart but she administered metoprolol tartrate 25mg as a substitute. -She did not check Resident #5's BP as ordered prior to administering metoprolol tartrate 25mg because she did not see a separate task in the eMar for checking Resident #5's BP. -Metoprolol succinate 25mg ER had been ordered from the pharmacy on 5/30/17 and was scheduled to arrive on 5/31/17. Review of Resident #5's BP check obtained by a	{D 358}		

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{D 358}	Continued From page 4 MA on 5/31/17 at 10:30 am revealed a result of 122/68. Telephone interview on 5/31/17 at 10:42 am with the facility's contracted pharmacy revealed: -Metoprolol succinate 25mg ER was an extended release medication used to treat high BP. -Metoprolol tartrate 25mg was an immediate release medication used to treat high BP. -Metoprolol succinate 25mg ER and metoprolol tartrate 25mg were two different medications and cannot be used interchangeably. -The pharmacy had no record of dispensing metoprolol succinate 25mg ER for Resident #5 prior to 5/30/17. -The pharmacy had dispensed 15 tablets of metoprolol tartrate 25mg for Resident #5 on 5/08/17. -The pharmacy was responsible for entering medications into the eMar system and the facility's RCD and Wellness Nurses were responsible for verifying they are correct. -If a separate order for daily BP checks was required in order for the MAs to be prompted to complete the task, the facility was responsible for entering those into the eMAR. Telephone interview on 5/31/17 at 11:27 am with the facility's backup pharmacy provider revealed they had no record of having dispensed metoprolol succinate 25mg ER or metoprolol tartrate 25mg for Resident #5. Telephone interview on 5/31/17 at 1:06 pm with the pharmacy provider for Hospice revealed they had no record of having dispensed metoprolol succinate 25mg ER or metoprolol tartrate 25mg for Resident #5.	{D 358}		

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{D 358}	Continued From page 5 Telephone interview on 5/31/17 at 11:41 am with the physician's assistant revealed: -She was not aware that daily BP checks were not being performed on Resident #5 as ordered. -Metoprolol tartrate 25mg should not be administered to Resident #5 without checking her BP first. -Metoprolol succinate 25mg ER should be administered to Resident #5 every day. -She was not aware the MAs were substituting metoprolol tartrate 25mg for metoprolol succinate 25mg ER. -Metoprolol succinate 25mg ER and metoprolol tartrate 25mg were two different medications and should not be used interchangeably for Resident #5 because one (metoprolol tartrate 25mg) is an immediate release BP medication and the other (metroprolol succinate 25mg ER) is an extended release BP medication. Interview on 5/31/17 at 2:00 pm with RCD revealed: -She was not aware MAs were substituting metroprolol tartrate 25mg for metoprolol succinate 25mg ER. -She was not aware MAs were not checking BP as ordered prior to administering metoprolol tartrate 25mg which was an as needed medication if SBP was greater than 150. -She was responsible for observing MAs and checking them off for administering medications properly. -MAs were taught to look at the resident's eMAR to know what medication to administer and compare it to the label on the bingo card three times prior to administering the med. -MAs should not be substituting metoprolol tartrate 25mg for metoprolol succinate 25mg ER. -MAs should not be administering metoprolol tartrate 25mg to Resident #5 without checking her	{D 358}		

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{D 358}	Continued From page 6 blood pressure first. Interview on 5/31/17 at 12:45 pm with the Executive Director revealed: -The MAs were supposed to check Resident #5's BP prior to administering metroprolol tartrate 25mg 1 tablet if SBP was greater than 150. -The MAs were supposed to compare the full name of each medication on the eMar to each residents' medication bingo card prior to administering. The facility failed to administer a blood pressure medication as ordered by the physician for Resident #5 who had a diagnosis of hypertension. The failure to administer metoprolol succinate 25mg ER and administering metoprolol tartrate 25 mg instead without obtaining a pre-administration blood pressure could have potentially resulted in hypotension that can lead to dizziness and loss of consciousness or hypertension which could result in heart attack, stroke or death. The failure of the facility to administer medications as prescribed by the physician was detrimental to the health and safety of residents and identified during a follow-up survey which constitutes an unabated Type B violation. CORRECTION DATE FOR THE UNABATED TYPE B VIOLATION SHALL NOT EXCEED JUNE 7, 2017.	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are	{D912}		

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{D912}	Continued From page 7 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding medication administration. The findings are: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 7 sampled residents (Resident #5), regarding metoprolol succinate 25mg ER and metoprolol tartrate 25mg. [Refer to Tag 358, 10A NCAC 13F .1004(a) (Unabated Type B Violation).]	{D912}		

Sunrise Senior Living, Inc.
Plan of Correction

Name of Community: Brighton Gardens of Winston Salem
Address: 2601 Reynolda Road Winston Salem, NC 27106
License number: HAL034026
Inspection date(s):
Name and Title of Sunrise Representative Signing the Plan of Correction:
Jennifer Kopp, Executive Director
Signature of Sunrise Representative: Jennifer Kopp
Date of Submission: 6/28/17
Reviewed and accepted 07/10/17 AJS

Regulation	Target Date by Which Correction will be completed	Plan of Correction
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.	5/30/2017 06/07/2017 06/21/2017	**A. With respect to the specific resident/situation cited:** Resident # 5: Notified doctor (PA) on day of survey 5/30/17. Medication error report completed on 5/30/17, family notified on 5/30/17. Resident was evaluated by Resident Care Director (RCD). Resident experienced no negative outcomes as a result of the event. Blood pressure checks, according to the original physician order, were added to eMAR. The contracted pharmacy conducted a re-training session for the wellness team and medication care managers (MA) with the support of the Resident Care Director (RCD) which included procedures for ordering medications, Six Rights of medication administration, and medication administration procedure. Resident # 5: FL2 form was updated to include the diagnosis that required the medications in question.
	06/07/17	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** During monthly wellness visits, the Resident Care Director (RCD), wellness nurse or designee will review orders and eMARs for accuracy.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	06/30/17 06/30/17	Contracted pharmacy nurse will conduct an audit of medications in the cart and eMAR's to confirm that medications match eMAR. The Resident Care Director (RCD), wellness nurse or designee completed an eMAR audit on residents which consisted of comparing the eMARs to the Physician Order Sheets (POSs) and to new orders or changes in orders that may have occurred after the eMARs were printed. During the audit, the Resident Care Director (RCD) and the wellness nurses made necessary revisions or additions to the MARs to confirm that the medication orders appeared accurately and clearly on the eMARs. On-site quarterly pharmacy audits occur including a medication order review of resident charts. This review incorporates a comparison with the eMARs to the charts and POS's.
	06/05/17 06/30/17	**C. With respect to what systemic measures have been put into place to address the stated concern:** The Resident Care Director (RCD) conducted a re-training session for the wellness team and medication care managers with the support of contracted pharmacy. The Resident Care Director (RCD) will conduct trainings with the wellness nurses and the medication care managers if discrepancies or issues are identified with the medication administration program, and from the results of the weekly eMAR audits; documentation of the trainings will be maintained. The Resident Care Director (RCD) will monitor eMAR accuracy by conducting regular eMAR reviews and medication pass observations for medication care managers Which will include reviewing and clarifying new orders or changes to existing orders. The Resident care Director (RCD) will confirm components of receiving, transcribing, and adhering to physician orders are in place; confirming related pharmacy communication occurs; and confirming that the month to month eMAR transition is accurately performed. The Resident Care Director (RCD) or designee will perform this audit on a weekly basis for three months. This will be re-evaluated after the three months.

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	6/30/17	**D. With respect to how the plan of correction will be monitored:** The Executive Director (ED) or designee will report the results of the weekly audit (or monthly reviews) at the Quality Assurance and Performance Improvement Meetings for three months. At the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.

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