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{D 000}	Initial Comments The Adult Care Licensure Section and the Mecklenburg County DSS conducted an Follow-up survey on June 19-20, 2018.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A1 VIOLATION. Based on these findings, the previous Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physician notification regarding 1 of 3 residents sampled (Resident #1) having increased risk of depression, and experiencing increased pain levels. The findings are: Review of Resident #1's current FL-2 dated 04/25/18 revealed: -Diagnoses included Post-polio syndrome, chronic pain, and hypertensive disease. -Resident #1 was non-ambulatory. -Resident #1 was incontinent of bowel and bladder. -An order for hydrocodone/acetaminophen (a	{D 273}		

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{D 273}	Continued From page 1	{D 273}		

medication used to test pain) 7.5/325 every 6 hours as needed for severe pain.
-An order for Fluoxetine (a medication used to treat depression) 10mg daily.

Review of Resident #1's Resident Register revealed she was admitted to the facility on 05/15/18.

Review of Resident #1's record revealed:
-A communication fax document dated 05/17/18 to Resident #1's physician noting that Resident #1 "refuses to take fluoxetine because it made her feel "terrible".
-An order to discontinue to fluoxetine 10mg daily dated 05/27/18.

Review of Resident #1's "Resident Log" notes revealed:
-On 05/24/18 Resident #1 was "refusing to come out for meals since she moved into the community on 05/15/18" and that "she will not come out for activities" and that the "resident is very emotional about her condition and her health" and that it "hurts her body to sit in her wheelchair for a long period of time."
-On 05/31/18 states "resident fluoxetine 10mg tab was discontinued. Will continue to monitor."
-On 06/7/18 states "Resident shower day was yesterday. Resident kept putting off until second shift came in, resident was giving a bath due to resident refusing to take a shower. Resident stated she just don't think she could do now, due to her post-polio syndrome. Resident also states the process of getting to the shower and taking a shower would "make her legs and arms hurt more."
-On 06/14/18 stated "resident refused her shower 3 times today around lunch time. She had company today and said she wasn't taking a

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{D 273}	Continued From page 2 shower at that time ...stated she would wait until Saturday." Review of Resident #1's May 2018 electronic Medication Administration Record (eMAR) revealed: -An entry for Hydrocodone-Acetaminophen 7.5-325mg every 6 hours as needed for severe pain, documented as administered 45 times during the month of May 2018, on the following occasions; once on 5/16/18, twice on 05/17/18, 05/18/18, and 05/26/18, three times on 05/19/18, 05/20/18, 05/22/18 - 05/25/18, 05/27/18, and 05/29/18-05/31/18, four times on 5/21/18 and 5/21/18. -An entry for the pain scale for Resident #1's pain levels were documented as an "8" on 16 occasions, a "9" on 10 occasions, and a "10" on 2 occasions. -There were 3 entries documented the month hydrocodone-acetaminophen as being "ineffective" on, 5/17/18 with a pain scale of "8" 3.5 hours after the medication was administered, 5/18/18 with a pain scale of "7" 2 hours after the medication was administered, and 5/27/18 with a pain scale of "9" 1.5 hours after the medication was administered. Review of Resident #1's June 2018 (June 1 - June 19) eMARs revealed: -An entry for hydrocodone-acetaminophen 7.5-325mg 1 tablet every 6 hours as needed for severe pain documented 44 times during June 1 - June 19, 2018, on the following occasions once on 06/5/18, twice on 06/02/18, 06/70/18, 06/08/18, 06/10/18, 06/14/18, and 06/19/18, three times on 06/03/18, 06/11/18 - 06/13/18, 06/17/18, and 06/18/18, four times on 06/01/18, 06/15/18, and 06/16/18.	{D 273}		

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{D 273}	Continued From page 3 -An entry for the pain scale for Resident #1's pain levels were documented as an "8" on 15 occasions, a "9" on 13 occasions, and a "10" on 3 occasions with all occasions documenting effective pain relief. Review of Resident #1's Record revealed: -There was no documentation in the record that the facility had communicated with the physician regarding the resident's emotional state, pain levels or the increased need for pain medication Interview with Resident #1 on 06/19/18 at 11:33am revealed: -She felt depressed and like a "mole in a hole" since being in the facility. -She received 2 showers since being in the facility, but they were "very painful" and "like to have killed her" because the shower chair caused an increase in pain. -She was "paralyzed from the waist down" and limited use of her left arm. Her left shoulder often hurt. -She had been "bed bound" for 2 years, only getting up to go to the doctor's office every 6 months. -Due to her post-polio syndrome, her muscles were "dying." -She felt "trapped" stated "I lie in the same sheets that are dirty ...stare at the same walls everyday ...I can't go to activities" because no staff help her to get up and get dressed to go out of her room. Observation of Resident #1 on 06/19/18 at 3:45pm revealed she was very emotional, tears with almost all responses. Interview with Resident #1 on 06/20/18 at 10:55am revealed: -Her left side hurt her, and it "could be from sitting	{D 273}		

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in the same position" all day in bed.
-No one spoke to her about mattress alternatives to reduce pain or to have the pain medication scheduled.

Interview with PCA on 06/20/18 at 11:15am revealed:
-Resident #1 often told her that "everything hurts." When the resident told her this, she would always tell the MA. Resident #1 always asked for a "pain pill" when she would first go into her room in the morning.
-She often observed Resident #1 to be sad and emotional. The resident often talked about not being able to see outside.
-Once during a shower, Resident #1 had even said she wanted to "kill herself." The PCA came out of the room immediately and reported this to the MA.
-She always reported Resident #1's behavior and emotional state to the MA. She did not know if this was reported to the doctor.

Interview with the Resident Care Coordinator/Medication Aide on 06/20/19 at 11:30am revealed:
-Resident #1 was sad since coming here.
-Resident #1 refused to take her fluoxetine soon after being admitted, so the RCC had the medication discontinued by the physician. Resident #1 was much more tearful recently. She did not think the physician was notified of the behavior change.
-Resident #1 asked for her hydrocodone/acetaminophen pill as often as she could get it, PRN every 6 hours.
-She did not know if the physician was notified that Resident #1 was requesting this medication as often as possible, or that her pain levels had often been 8-10 on a scale of 10.

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{D 273}	Continued From page 5 -She did not communicated with the physician about Resident #1's shower refusals or challenges with toileting. -Resident #1 often reported to her that her legs hurt, but other times would say she "couldn't feel them." Interview with Administrator on 06/20/18 at 9:35am revealed: -Resident #1 often requested her pain medication as often as possible. She did not know if this was communicated to the physician. She did not know if a prescription for a scheduled dose rather than PRN was considered. Either the RCC or the HWD would have communicated with the physician about this. -Resident #1's emotions had a wide range. Last week when she spent time with her, Resident #1 was emotional and crying often, but today, she was more upbeat. -Resident #1 continued to have "refusal after refusal" for coming out to meals, participating in activities because of the pain of getting out of bed. -Resident #1 would state that she didn't want to get up because "it was painful." She was not certain as of the cause of this pain, but Resident #1 often attributed her pain to post-polio syndrome. -She did not know if the facility had discussed her pain associated with getting out of bed, and unwillingness to participate in meals or activities because of her pain level, or her requesting her PRN hydrocodone/acetaminophen as often as possible with her physician. Telephone Interview with Resident #1's Physician on 06/21/18 at 1:03pm revealed: -She had treated the Resident #1 for many years, mostly for pain management and primary care	{D 273}		

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needs.
-When Resident #1 was at home, she was able to transfer from her bed to her motorized wheelchair independently, which is why she felt she was appropriate for assisted living level of care at the time she completed the FL-2 in April.
-Resident #1 was in chronic pain related to post-polio syndrome and had always taken her pain medications "as often as possible" when she was at home.
-The facility did not communicated with her regarding possibly scheduling her dose of hydrocodone/acetaminophen instead of a PRN dose. She would be willing to change the order to scheduled, if it would better meet Resident #1's needs.
-The facility did not communicated with her regarding Resident #1's pain levels or the effectiveness of the hydrocodone/acetaminophen since she had been in the facility.
-She did not know Resident #1's complaints of pain specifically in her right thigh, her left shoulder, and her right heal (severe burning sensation).
-The facility requested an order to discontinue fluoxetine 10mg every day on 05/22/18, which she approved because of refusals to take the medication.
-In the past the resident would often refuse new medications that she tried to introduce to her, so she was not surprised of her refusal of Fluoxetine.
-The facility did not communicated with her after she had discontinued fluoxetine regarding Resident #1's increased tearfulness and emotional state.
-The facility did requested an order for a social work evaluation on 06/7/18 related to "adjustment disorder." There was an additional request on 06/11/18 for the social worker to see the resident

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{D 273}	Continued From page 7 an additional 2 weeks, once a week. -The facility did not communicated with her regarding Resident #1's bath/shower refusals. -She did not know that Resident #1 was staying in bed all the time and that her mattress was flat. _____ The facility failed to notify Resident #1's physician regarding the increased amount of pain and the increased need for pain medication, her increased tearfulness and emotional state after the refusals of the fluoxetine. The failure of the facility to notify the physician was detrimental to the health, safety and wellbeing of Resident #1 and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/28/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 4, 2018.	{D 273}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure contact with the prescribing physician for clarification of orders for 1 of 3 sampled residents, (#2), related to an	{D 310}		

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{D 310}	Continued From page 8	{D 310}		

addendum to the FL2 that contained diet orders for a nutritional supplement twice a day, not signed by a physician.

The findings are:

Review of Resident # 2's current FL2 dated 05/31/18 revealed:
-Diagnoses included a left hip fracture, abdominal aortic aneurysm, hematuria, hypothyroidism and hypertension.
-There was an order for a textured modified diet with honey thickened liquids.

Review of Resident #2's "Addendum to the FL2" revealed:
-The addendum was a facility generated document that did not indicate who completed the form.
-The addendum did not accompany the FL2.
-The addendum included a textured modified diet with honey thickened liquids and a nutritional supplement twice a day.
-The addendum was not dated or signed by a physician.
-There was no physician order for nutritional supplements.

Review of Resident #2's electronic medication administration record (eMAR) for June 2018 revealed:
-There was an entry for nutritional supplements, scheduled to be administered twice a day at 8:00am and 7:00pm.
-There was documentation the resident had been administered nutritional supplements twice a day from 06/02/18 to 06/19/18.

Interview with the Resident Care Coordinator (RCC) on 06/19/18 at 3:32pm revealed:

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{D 310}	Continued From page 9 -The Health and Wellness Director (HWD), the RCC and designated medication aides (MAs) entered new orders into the eMAR system. -The HWD received FL2s and all new orders for the residents. -When a designated MA entered new orders, the RCC provided oversight and reviewed the entry. -When the RCC entered new orders, the HWD provided oversight and reviewed the entry. -The RCC had entered the diet order and nutritional supplements twice a day on the facility FL2 Addendum. She had added the nutritional supplements to the diet order on the FL2 due to his weight loss since he had been out of the facility. -She entered the FL2 medication orders and the nutritional supplements on the eMAR on 06/01/18. -She thought she had sent the Addendum to the PCP for her signature. -She realized she should not have entered the nutritional supplement order until the FL2 Addendum had been signed by the physician. -She did not follow the facility process for entering new orders. Record review revealed: -On 03/18/18, Resident #2 weighed 150 pounds. -Resident #2 was out of the facility for the April and May weight recording. -On 06/18/18, Resident #2 weighed 134 pounds. Interview with the first shift medication aide (MA) on 06/20/18 at 10:15am regarding the procedure for processing new orders on an FL2, or FL2 addendum revealed: -The RCC or MA who admitted the resident to the facility faxed the FL2 to the pharmacy with the medications listed. -The MA was not sure if the FL2 or the FL2	{D 310}		

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{D 310}	Continued From page 10	{D 310}		

Addendum was sent to the PCP.
-She had never sent an FL2 Addendum to the PCP or pharmacy.
-She would give both the FL2 and FL2 Addendum, if there was one, to the RCC.
-The RCC or designated MA transcribed the new orders onto the eMAR.
-The RCC or MAs filed the FL2 and the FL2 Addendum in the chart.
-As an MA, she was responsible for administering orders entered on the eMAR.
-She would not put an order on the eMAR if it did not have a physician's signature.
-She did not know the nutritional supplements were not ordered by the physician.

Interview with the second MA on 06/20/18 at 10:25am revealed:
-When she received orders from a prescribing practitioner or a new FL2, she recorded the orders in the New Order Tracking form.
-She transcribed the orders into the eMAR system.
-She documented in the resident's chart when a new order had been received.
-She faxed the orders to the pharmacy.
-If there was a signed order on the FL2 Addendum she would fax the order to the pharmacy.
-She would give the FL2 or FL2 Addendum to the RCC or HWD to review.
-She did not know who was responsible to fax the FL2 or FL2 Addendum to the PCP.
-She would not enter an order on the eMAR without a physician's signature.

Interview with the Executive Director (ED) on 06/20/18 at 11:15am revealed:
-The HWD and RCC should be following the facility policy regarding re-admission to the facility

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{D 310}	Continued From page 11 and processing new orders. -The policy included the responsibility of the HWD to "review all admissions/re-admissions to assure orders were processed correctly and clarifications were obtained if needed." -The staff should not enter an order onto the eMAR if the order has not been signed by the physician. -The Area Health and Wellness Director (AHWD) was assisting the facility in a clinical capacity. Interview with AHWD on 06/20/18 at 11:32pm revealed: -She was assisting the clinical department while the HWD was unavailable. -She had provided training to the RCC and MA's on 06/07/18 regarding the facility's re-admission checklist. -The checklist included a directive to notify the nurse if there were new orders or orders that were changed. -It did not indicate who was responsible for getting clarification from the PCP on re-admission orders. -It was the responsibility of the HWD or the RCC to clarify orders with the physician. -She did not know the staff were inconsistent in implementing the process for new orders. -She did not know the request for an order for nutritional supplements twice a day had not been sent to the PCP. -She did not know the nutritional supplements, scheduled for twice a day, had been entered on the eMAR and administered since 06/02/18, without a physician's signature. -She had spoken to the RCC who re-admitted Resident #2 and re-iterated the procedure for entering new orders on the eMAR before the PCP had signed the orders.	{D 310}		

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{D 310}	Continued From page 12 Interview with the nurse at the primary care physician's (PCP) office on 06/20/18 at 8:25am revealed: -There was no record the facility had sent a request for nutritional supplements for Resident #2. -There was no record the FL2 from re-admission to the facility was sent to the PCP. -The PCP did not know Resident #2 had a significant weight loss while at the rehabilitation facility. Based on interview, record review and observation it was determined Resident #2 was not interviewable.	{D 310}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A 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 quantity 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	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060060	A. BUILDING: _____ B. WING _____	R 06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHARLOTTE EAST	6053 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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 367	Continued From page 13 documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to ensure 1 of 3 sampled residents, (#2), electronic medication administration record (eMAR) was accurate as related to the dosage of Aricept. The findings are: Review of Resident #2's current FL2 dated 05/31/18 revealed medications included Aricept 10mg, take 1 tablet at bedtime, used to treat mild to severe demnetia with Alzheimer's disease. Observation of the medication cart on 06/19/18 at 2:45pm revealed: -A bubble pack for Aricept labeled 10mg, take 1 tablet each evening at bedtime. -The label on the bubblepack revealed thirty 10mg tablets of Aricept were dispensed from the pharmacy on 06/02/18. -No other packaging for Aricept with a different dosage was on the cart. -There were 17 pills missing from the bubble pack. Review of the eMAR for June 2018 revealed: -An entry for Aricept 5mg take 1 tablet before bedtime, scheduled to be administered at 8:00pm. -There was documentation of administration of Aricept 5mg from 06/02/18 to 06/18/18. -There was no entry for Aricept 10 mg to be administered. -There was no documentation that the dosage on the label of the bubble pack differed from the	D 367		

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D 367	Continued From page 14 dosage on the eMAR. Interview with the pharmacist contracted by the facility on 06/19/18 at 3:00pm revealed: -The most recent order on the pharmacy profile for Resident #2 was Aricept 10mg at bedtime, per the FL2 dated 5/31/18. -The pharmacy had not received an order for Aricept 5mg 1 tablet at bedtime. -The pharmacy sent 30 tablets of Aricept 10mg in a bubble pack on 06/01/18. -The pharmacy changed the resident's profile when they received new orders. -The pharmacy software did not interface with the facility's eMAR system. -The pharmacy staff could not enter or remove an entry on the eMAR. -The pharmacists could not view entries the facility made on their eMAR. -The pharmacist did not know that the entry on the eMAR for Aricept was a 5mg dosage. Interview with Resident Care Coordinator (RCC) on 06/19/18 at 3:32pm revealed: -The Health and Wellness Director (HWD), RCC and certain medication aides (MAs) entered new orders into the eMAR. -The HWD received new orders for all the residents. -The RCC or designated MA entered the orders into the eMAR. -When the MA entered the orders, the RCC provided oversight. -When the RCC entered the orders, the HWD provided oversight. -She entered the Aricept 10mg order incorrectly as Aricept 5mg. -She had a documented cart audit on 06/07/18 and a cart audit on 06/14/18 that she had completed.	D 367		

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D 367	Continued From page 15 -There was no documentation during these cart audits the Aricept entered on the eMAR (5mg) was a different dosage than the medication label on the Aricept bubble pack (10mg). Interview with Area Health and Wellness Director (AHWD) on 06/19/18 at 2:20pm revealed: -She trained the RCC and the MAs regarding the process for verifying orders as follows; to print the resident's eMAR , to match the eMAR to the current FL2 or orders, highlight the orders that have changed or been omitted and send the primary care physician (PCP) a clarification request if needed. -The RCC is responsible for completing weekly cart audits. -She does not know why the RCC did not correct this error during a cart audit. -The training for processing new orders took place on 06/07/18 at the facility. Interview with the Executive Director (ED) on 06/20/18 at 11:15am revealed: -The HWD and RCC should have followed the facility policy regarding re-admission to the facility and processing new orders. -The policy included the responsibility of the HWD to "review all admissions/re-admissions to assure orders were processed correctly and clarifications were obtained if needed." -She did not know the Aricept order was entered on the eMAR incorrectly. -The HWD was unavailable at this time and it was unclear if she had reviewed Resident #2's FL2 or eMAR before she left. -The AHWD was assisting the facility in the absence of the HWD.	D 367		

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{D912}	Continued From page 16	{D912}		
{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 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 assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to assure physician notification regarding 1 of 3 residents sampled (Resident #1) having increased risk of depression, and experiencing increased pain levels. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	{D912}		