



August 1, 2019

Mary E. Agena, RN, BSN  
Adult Care Licensure Section  
Division of Health Service Regulation

Dear Ms. Agena:

Enclosed please find our submitted plan of correction for the survey dated June 19, 2019. I look forward to your feedback and guidance.

It was a pleasure to meet you and your team during our survey process. Please let La'Tasha or I know if you are in need of any additional information.

Best Regards,

A handwritten signature in black ink, appearing to read 'Christine M. Ogden', is written over the typed name.

Christine M. Ogden, CALA, CDAL  
Administrator



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/19/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE COTSWOLD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3610 RANDOLPH ROAD CHARLOTTE, NC 28211</b>
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D 000	Initial Comments  The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey and complaint investigation on 06/17/19-06/19/19.	D 000		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings  10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities.  This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure upholstered chairs in common areas throughout the facility were clean and in good repair.  The findings are:  Observation the second-floor common area on 06/17/19 at 9:15am revealed: -There were 2 upholstered chairs; green, tan and cream colored, outside of the dining room. -There were stains in the seat and arm rests of both chairs. -The seats of the chairs were soiled and had a strong urine odor. -There was a tan colored love seat sofa across from the dining room that had stains in the seat. -The love seat was soiled and smelled of urine.  Observation of the common area in the special care unit (SCU) on 06/17/19 at 9:25am revealed: -There were 2 upholstered chairs; green, tan and cream colored, next to the dining area.	D 076	D076  Furniture has been cleaned and quarterly cleaning of the furniture will be added the rotating cleaning schedule. New cleaning equipment has been ordered for spot cleaning.	

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Christine McQueen, Administrator*  
STATE FORM 6899 ET9K11 TITLE (X6) DATE  
*8/2/19*  
If continuation sheet 1 of 44

*As to LSC for HMD 8/2/19*

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D 076	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>-There were stains in the seat and arm rests of both chairs.</li> <li>-There was food and crumbs in the seat of the chairs.</li> <li>-There was a tan colored love seat that had several stains in the seats of the chair.</li> </ul> <p>Observation of the third floor common area on 06/17/19 at 11:30am revealed:</p> <ul style="list-style-type: none"> <li>-There was a multicolored upholstered love seat was stained with a brown material.</li> <li>-There was an upholstered chair that had multiple brown stains on the seat and arms.</li> <li>-The seats of the chairs were soiled and had a strong urine odor.</li> </ul> <p>Interview with the two housekeepers on 06/19/19 at 10:02am revealed:</p> <ul style="list-style-type: none"> <li>-They were responsible for cleaning the common areas throughout the facility.</li> <li>-They cleaned the fabric of the love seat sofas when the residents had accidents.</li> <li>-They removed the fabric on the seat cushions and placed them in the washing machine when needed.</li> <li>-They cleaned the fabric, but the urine smell was in the cushion of the chairs and the scent could not be removed.</li> <li>-They both told management of the condition of the furniture and nothing had been done.</li> <li>-They used stain remover to clean the upholstered chairs on each floor weekly, however some stains would not come out.</li> <li>-The upholstered chairs smelled of urine because they were unable to clean the cushion.</li> </ul> <p>Interview with a personal care aide (PCA) on 06/19/19 at 11:40am revealed:</p> <ul style="list-style-type: none"> <li>-She noticed the stains in the chairs in the memory care unit "a while ago".</li> </ul>	D 076		

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D 076	<p>Continued From page 2</p> <p>-They placed the seat fabric in the washing machine often because the residents had accidents regularly.</p> <p>Interview with a PCA on 06/19/19 at 11:55am revealed: -She smelled odors coming from the chairs in the common areas. -She placed the fabric from the seat into the washing machine when needed, but the odor remained.</p> <p>Interview with a resident on 06/19/19 at 12:05 revealed: -He noticed the stains on the chairs in the building. -The seats "smelled". -He wished the furniture could be changed.</p> <p>Interview with two residents on 06/19/19 at 1:58pm revealed: -They noticed stains on the sofa. -There were smells of urine in the common area. -He never mentioned the odor of the furniture to anyone.</p> <p>Interview with the Administrator on 06/19/19 at 12:08pm revealed: -She observed the condition and odor of the chairs in the common areas throughout the facility. -She requested a quote to deep clean the entire facility and had a hard time getting the corporate office to approve. -She requested that the furniture be replaced throughout the facility. -A contracted company came to clean the carpet and they also spot clean the upholstered furniture.</p>	D 076			

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D 076	Continued From page 3  Telephone interview with the contracted cleaning company on 06/19/19 at 2:44pm revealed: -The company provided cleaning services for the facility quarterly. -The company provided only carpet cleaning services to the facility. -They never provided cleaning for the furniture in the facility.	D 076		
D 132	10A NCAC 13F .0406(b) Test For Tuberculosis  10A NCAC 13F .0406 Test For Tuberculosis (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others.  This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 6 sampled staff (Staff C) was tested for tuberculosis (TB) disease upon hire.  The findings are:  Review of Staff C's, a medication aide (MA), employee record revealed: -The hire date for Staff C by a temporary staffing agency was 07/05/16. -There was documentation a TB skin test was completed on 06/19/17. -There was no documentation of a second TB skin test in the employee record.  Review of the staffing schedule for 06/18/19 and 06/19/19 revealed Staff C was scheduled as a third shift MA.	D 132	D132 – TB Test  New procedure implemented for temporary staffing and standards updated with agency to include all necessary requirements for temporary staff.  Employee file audits will be conducted monthly for next 90 days and then quarterly moving forward.	

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D 132	<p>Continued From page 4</p> <p>Attempted telephone interview with Staff C on 06/19/19 at 3:00pm was unsuccessful.</p> <p>Telephone interview with the temporary staffing agency on 06/19/19 at 2:45pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff C had been hired by the staffing agency on 07/05/16 as a MA.</li> <li>-The staffing agency signed a contract with the facility for temporary staffing of Staff C on 05/07/19.</li> <li>-Staff C had been working as a MA as needed on third shift since 05/17/19.</li> <li>-Staff C had a TB skin test on 06/16/17 that was read on 06/19/17 with a negative result.</li> <li>-The staffing agency did not perform a two step TB skin test on temporary staff unless the facility requested at the time of signing the temporary staff member's contract.</li> <li>-The facility had not requested a second TB skin test for Staff C.</li> </ul> <p>Interview with the Business Office Manager (BOM) on 06/19/19 at 9:00 am revealed:</p> <ul style="list-style-type: none"> <li>-Staff C had began working on 05/17/19 after a temporary staffing contract was signed with a temporary staffing agency.</li> <li>-Since she had started working as the BOM in April 2019 she had not audited the staff records to ensure all the staff had completed a two-step TB skin test.</li> <li>-She was not aware Staff C did not have a two-step TB skin test.</li> </ul> <p>Interview with the Administrator on 06/19/19 at 2:30pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff C was from a temporary staffing agency.</li> <li>-She did not know Staff C did not have a two-step TB skin test.</li> <li>-She had been informed by the temporary staffing agency today that they did not perform two-step</li> </ul>	D 132		

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D 132	Continued From page 5  TB skin test unless the facility had requested it when they signed the staffing contract. -She had recently hired a new BOM and she had not audited the staff records. -She was currently working with the BOM to design a system to effectively audit staff records for completeness.	D 132		
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, interviews, and record reviews, the facility failed to assure administration of medications as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (#1, #4, and #5) related to a thyroid medication (#1), medications for prevention of blood clotting (#5), and a medication for hypertension (#4).	D 358	D358 – Medication Administration  Frequent cart audits are being conducted throughout community by HWD, RCC and SIC weekly. Additionally, two audits have been completed by Pharmacy since survey. HWD met with pharmacy and refills will be provided through "Ready-Fill" to eliminate missed refills.  QA check put in place for nightshift as secondary check for refills.	

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D 358	<p>Continued From page 6</p> <p>The finding were:</p> <p>1. Review of Resident #1's current FL2 dated 10/29/18 revealed diagnoses included acute kidney failure, dementia, hypertension, diabetes and transischemic attack.</p> <p>Review of Resident #1's physician's orders revealed an order dated 11/13/18 for levothyroxine Sodium 50mcg every day.</p> <p>Review of Resident #1's April 2019 electronic Medication Administration Record (eMAR) revealed an entry for levothyroxine Sodium 50mcg every morning documented as administered 04/01/19 through 04/30/19 at 7:00am.</p> <p>Review of Resident #1's May 2019 eMAR revealed:</p> <ul style="list-style-type: none"> <li>-An entry for levothyroxine sodium 50mcg every morning documented as administered 05/01/19 through 05/07/19 at 7:00am.</li> <li>-An entry for levothyroxine sodium 50mcg every morning with no documentation of administration from 05/08/19 through 05/11/19 at 7:00am.</li> <li>-An entry for levothyroxine sodium 50mcg every morning documented as administered 05/12/19 at 7:00am.</li> <li>-An entry for levothyroxine sodium 50mcg every morning with no documentation of administration from 05/13/19 through 05/15/19 at 7:00am.</li> <li>-An entry for levothyroxine sodium 50mcg every morning documented as administered 05/16/19 through 05/31/19 at 7:00am.</li> <li>-There was no documentation to justify the levothyroxine sodium 50mg not being administered 05/08/19 through 05/11/19 and 05/13/19 through 05/15/19 at 7:00am.</li> </ul>	D 358	<p>Orders no longer being entered at community level except by HWD and RCC, new system implemented that pharmacy will be entering all orders. Clinical team will verify new orders entered by pharmacy and will not release until that second check has occurred and medication is in community.</p> <p>New EMAR system in place as of July 1<sup>st</sup>. HWD receives notification immediately of any refusal or missed medications.</p> <p>QA will include monthly audit for 90 days and quarterly audit moving forward of 10% of all medication carts for appropriate notification of missed or refused medications.</p>	

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D 358	<p>Continued From page 7</p> <p>Review of Resident #1's progress notes on 06/17/19 at 12:03pm revealed:</p> <ul style="list-style-type: none"> <li>-On 05/11/19, the levothyroxine sodium 50mcg was documented as "awaiting new script".</li> <li>-On 05/13/19, the levothyroxine sodium 50mcg was documented as the pharmacy "was notified to refill medicine".</li> <li>-On 05/14/19, the levothyroxine sodium 50mcg was documented as "on order".</li> <li>-On 05/15/19, the levothyroxine sodium 50mcg was documented as "awaiting new script".</li> </ul> <p>Review of Resident #1's June 2019 eMAR revealed an entry for levothyroxine Sodium 50mcg every morning documented as administered 06/01/19 through 06/17/19 at 7:00am.</p> <p>Interview with Resident #1 on 06/17/19 at 10:27am revealed:</p> <ul style="list-style-type: none"> <li>-She only received "4 pills" every morning and she only received 3 this morning (06/17/19).</li> <li>-She was not receiving the correct number of pills every morning.</li> <li>-On 06/16/19 she only received 2 of the 4 morning pills.</li> <li>-She noticed many times in the past 2 months she was not administered 4 pills every morning.</li> <li>-She reported to the MA when she received less than 4 pills and was told that her medication ran out and needed to be reordered.</li> </ul> <p>Observation of medications on hand for administration for Resident #1 on 06/17/19 at 11:08am revealed the levothyroxine was not available for administration.</p> <p>Interview with a medication aide (MA) on 06/17/19 at 11:08am revealed:</p>	D 358		

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D 358	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-She administered the last of Resident #1's levothyroxine this morning (06/07/19).</li> <li>-She tore off the top of the bubble pack of the levothyroxine and peeled the sticker off of the levothyroxine bubble pack and faxed it to the pharmacy for re-order.</li> <li>-She threw away the lower part of the bubble pack and placed the top in the shredder after pulling the sticker off.</li> <li>-The MAs were to re-order a medication when there were 7 doses left.</li> <li>-She did not know why the levothyroxine was not re-ordered before today 06/17/19.</li> <li>-She checked the extra storage of medications and Resident #1 did not have any extra levothyroxine.</li> </ul> <p>Telephone interview with a representative from the facility's contracted pharmacy on 06/17/19 at 2:55pm revealed:</p> <ul style="list-style-type: none"> <li>-The levothyroxine sodium 50mcg every day would only be dispensed to the facility after the facility called for refill.</li> <li>-On 03/29/19, an order for levothyroxine sodium 50mcg every day with 30 tablets was dispensed to the facility.</li> <li>-On 05/15/19, levothyroxine sodium 50mcg with 30 tablets were dispensed to the facility.</li> <li>-The 30 tablets requested and dispensed on 03/29/19 were to start on 03/30/19 and would have run out on 04/29/19.</li> <li>-The 30 tablets dispensed on 05/15/19 indicated there were 16 doses Resident #1 missed before the facility had the levothyroxine sodium 50mcg refilled.</li> <li>-On 06/17/19, levothyroxine sodium 50mcg every day was ordered, and 30 tablets were sent to the facility to be administered starting on 06/18/19.</li> </ul> <p>Interview with the HWD on 06/18/19 at 9:16am</p>	D 358		
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D 358	<p>Continued From page 9</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-She did not know Resident #1 did not receive the levothyroxine sodium 50mcg every day from 05/08/19-05/11/19 and 05/13/19-05/15/19 as documented on Resident #1's May 2019 eMAR.</li> <li>-She did know Resident #1's levothyroxine sodium 50mcg every day was not ordered when there were 7 doses left to be administered.</li> </ul> <p>A telephone interview with Resident #1's primary physician on 06/19/19 at 9:20am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1's last Thyroid Stimulation Hormone (TSH) was last checked in November 2018 and required Resident #1 to take levothyroxine Sodium every day.</li> <li>-She expected the facility staff to administer the medication as ordered.</li> <li>-Resident #1 could display symptoms of increased tiredness, weight gain and dry skin if the levothyroxine sodium was not taken as ordered.</li> </ul> <p>Interview with the RCC on 06/19/19 at 10:00am revealed she did not know why Resident #1's levothyroxine was not ordered when the resident had 7 days of medication left.</p> <p>Refer to review of the Medication Aide Training dated 03/27/19.</p> <p>Refer to interview on 06/18/19 at 9:16am with the HWD.</p> <p>Refer to interview on 06/19/19 at 10:00am with the RCC .</p> <p>Refer to interview on 06/19/19 at 10:30am with the Administrator .</p> <p>Refer to interview on 06/19/19 at 1:40pm with the</p>	D 358		

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D 358	<p>Continued From page 10</p> <p>Administrator.</p> <p>Refer to interview on 06/19/19 at 2:20pm with the RCC.</p> <p>2. Review of Resident #5's current FL2 dated 01/21/19 revealed: -Diagnoses included dementia with behaviors, hypertension, edema, gastrointestinal bleed, atrial fibrillation, diverticulitis, and hyperlipidemia. -A physician's order for Xarelto (a blood thinner used to prevent clotting) 10mg daily.</p> <p>Review of Resident #5's record revealed: -A physician's order dated 02/26/19 for Xarelto 10mg daily. -A physician's order dated 04/01/19 for Xarelto 15mg daily.</p> <p>Review of Resident #5's April 2019 electronic medication administration record (eMAR) revealed: -An entry for Xarelto 10mg daily at 8:00am. -Xarelto 10mg was documented as administered daily from 04/01/19 to 04/30/19 at 8:00am. -There was no entry for Xarelto 15mg on the eMAR for April 2019.</p> <p>Review of Resident #5's May 2019 eMAR revealed: -An entry for Xarelto 10mg daily at 8:00am with a start date of 01/24/19 and a discontinue date of 05/28/19. -Xarelto 10mg was documented as administered daily from 05/01/19 to 05/27/19 at 8:00am. -A second entry for Xarelto 10mg daily at 8:00am with a start date of 05/29/19, that was documented as administered on 05/31/19. -There was no documentation of Xarelto 10 mg administered on 05/29/19 and 05/30/19.</p>	D 358		

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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE COTSWOLD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3610 RANDOLPH ROAD CHARLOTTE, NC 28211</b>		
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D 358	<p>Continued From page 11</p> <p>-There was an entry for Xarelto 15mg with a start date of 05/29/19 and a discontinue date of 05/28/19.</p> <p>Review of Resident #5's facility Progress Notes revealed Xarelto 10mg was documented as on order for 5/28/19 to 05/30/19.</p> <p>Further review of Resident #5's record revealed: -There was no clarification order obtained related to the 04/01/19 order for Xarelto 15mg. -A physician's clarification order dated 05/28/19 for Xarelto 10mg daily.</p> <p>Interview on 06/17/19 at 8:29am with a representative from Resident #5's physician's office revealed: -They had never changed Xarelto 10mg dose to 15mg. -The physician that wrote the order for the 15 mg did not work at their office. -Resident #5 was supposed to be taking Xarelto 10mg daily.</p> <p>Interview on 06/17/19 at 8:40am with the Health and Wellness Director (HWD) revealed: -She did not clarify the 04/01/19 order for Xarelto 15mg with Resident #5's physician. -She had sent the Xarelto 15mg tablets back to the pharmacy. -Resident #5 had been at a rehabilitation facility and her previous physician had sent the order for the 15mg on 04/01/19.</p> <p>A second interview on 06/17/19 at 10:59am with the HWD revealed: -She had found the pharmacy delivery sheets for 03/22/19 for Xarelto 10mg and 04/01/19 for Xarelto 15mg. -The last shipment from the pharmacy was for</p>	D 358		

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D 358	<p>Continued From page 12</p> <p>Xarelto 10mg on 05/28/19.</p> <ul style="list-style-type: none"> <li>-The MAs administered Xarelto 15mg to Resident #5, when the eMAR for April and May 2019 instructed to administer 10mg daily.</li> <li>-She could not provide documentation of Xarelto 15mg being returned to the pharmacy.</li> </ul> <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/19/19 at 10:22am revealed:</p> <ul style="list-style-type: none"> <li>-They dispensed thirty tablets of Xarelto 10mg on 02/26/19 and 3/22/19.</li> <li>-They dispensed thirty tablets of Xarelto 15mg on 04/01/19 with no refills.</li> <li>-The facility did not return the Xarelto 15mg tablets that were ordered on 04/01/19.</li> </ul> <p>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/19/19 at 11:45am revealed:</p> <ul style="list-style-type: none"> <li>-The pharmacy received an order for Xarelto 10mg daily dated 02/26/19 for Resident #5 with 2 refills.</li> <li>-They dispensed thirty tablets of Xarelto 10mg on 02/26/19 and 3/22/19.</li> <li>-They received a signed physician's order on 04/01/19 for Xarelto 15mg daily.</li> <li>-They discontinued the Xarelto 10mg daily that was filled on 03/22/19 when they received the new order on 04/01/19.</li> <li>-The facility did not return the Xarelto 10mg tablets that were discontinued on 04/01/19.</li> <li>-They dispensed thirty tablets of Xarelto 15mg on 04/01/19 with no refills.</li> <li>-They received a signed physician's order on 05/28/19 for Xarelto 10mg daily.</li> <li>-They dispensed thirty tablets of Xarelto 10mg on 05/28/19 with eleven refills.</li> <li>-The pharmacy entered new or changed orders into the eMAR.</li> </ul>	D 358		

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D 358	<p>Continued From page 13</p> <p>-She could not explain why the order for Xarelto 15mg did not show up on the April 2019 or May 2019 eMAR.</p> <p>Attempted telephone interview on 06/19/19 at 2:00pm with Resident #5's Power of Attorney was unsuccessful.</p> <p>Review of the facility's pharmacy provider delivery sheet dated 03/22/19 at 3:45pm revealed there were thirty Xarelto 10mg tablets dispensed for Resident #5.</p> <p>Review of the facility's pharmacy provider delivery sheet dated 04/01/19 at 7:39pm revealed there were thirty Xarelto 15mg tablets dispensed for Resident #5.</p> <p>Review of the facility's pharmacy provider delivery sheet dated 05/29/19 at 7:18pm revealed there were thirty Xarelto 10mg tablets dispensed for Resident #5.</p> <p>Observation of medications on hand for Resident #5 on 06/17/19 at 10:00am revealed a bubble pack of Xarelto 10mg with 14 of 30 tablets remaining, that was dispensed on 5/28/19.</p> <p>Interview on 06/19/19 at 10:50am with a medication aide (MA) revealed:          -She had administered Xarelto 10mg to Resident #5 since the prescription was filled in January 2019.          -She had administered Xarelto 10mg for the month of April 2019.          -She had never administered the 15mg dose that was ordered on 04/01/19.          -New orders were faxed to the pharmacy by the MAs.          -A New Order Tracking Form was filled out and</p>	D 358		

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D 358	<p>Continued From page 14</p> <p>sent to the Resident Care Coordinator (RCC).</p> <ul style="list-style-type: none"> <li>-The new order was entered into the eMAR by the MA and the order was placed in the resident's chart.</li> <li>-The RCC was responsible to compare new orders to the eMAR and to the medications received with the New Order Tracking Form.</li> <li>-The night shift MA was responsible to check in new medications that were delivered from the pharmacy.</li> <li>-The night shift MA would notify the oncoming day shift MA of the new orders and the day shift MA would call the pharmacy if there was a discrepancy.</li> <li>-The MAs were responsible for sending medications back to the pharmacy that had been changed or discontinued.</li> <li>-The HWD kept the Return to Pharmacy sheets in a binder in her office.</li> </ul> <p>Interview on 06/19/19 at 11:25am with a second MA revealed:</p> <ul style="list-style-type: none"> <li>-The only clarification order requested for Resident #5 was submitted to the physician on 05/27/19 for Xarelto 10mg versus 15mg.</li> <li>-The pharmacy had sent over a fax stating they did not have any refills for the Xarelto 15mg.</li> <li>-She compared the eMAR to the fax received from the pharmacy and realized the eMAR had 10mg instead of 15mg.</li> <li>-She could not find documentation of the 15mg tablets being returned to the pharmacy.</li> <li>-She could not find any pharmacy invoices that showed 10mg being sent or received by the facility for April 2019.</li> </ul> <p>Interview on 06/19/19 at 11:30am with the RCC revealed:</p> <ul style="list-style-type: none"> <li>-The facility had not requested clarification for Resident #5's Xarelto 15mg order that was dated</li> </ul>	D 358		

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D 358	<p>Continued From page 15</p> <p>04/01/19. -She did not have a New Order Tracking form for the 04/01/19 order.</p> <p>Interview on 06/19/19 at 1:40pm with the Administrator, revealed: -She was not aware Xarelto 15mg was given to Resident #5, when the eMAR listed 10mg as the current order. -She was not aware Xarelto 10mg was given to Resident #5, when there was an order on 04/01/19 for 15mg.</p> <p>Interview on 06/19/19 at 2:43pm with a MA revealed she could not find the facility's pharmacy provider delivery sheet for February 2019.</p> <p>Refer to review of the Medication Aide Training dated 03/27/19.</p> <p>Refer to interview on 06/18/19 at 9:16am with the HWD.</p> <p>Refer to interview on 06/19/19 at 10:00am with the RCC .</p> <p>Refer to interview on 06/19/19 at 10:30am with the Administrator .</p> <p>Refer to interview on 06/19/19 at 1:40pm with the Administrator.</p> <p>Refer to interview on 06/19/19 at 2:20pm with the RCC.</p> <p>3. Review of Resident #4's current FL2 dated 01/31/19 revealed: -Diagnoses included hypertension, history of hypo-osmolarity, spinal stenosis and osteoarthritis.</p>	D 358		

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D 358	<p>Continued From page 16</p> <p>-A physician order for enalapril maleate 20mg (used to treat hypertension) one tablet two times a day.</p> <p>Telephone interview with facility's contracted pharmacy on 06/18/19 at 2:03pm revealed the pharmacy dispensed enalapril maleate 20mg (60 tablets) on 04/02/19, 05/14/19 and 06/06/19.</p> <p>Review of Resident's #4's electronic Medication Administration Record (eMAR) for May 2019 revealed:</p> <p>-An entry for enalapril maleate 20mg scheduled for administration on 05/28/19 through 05/31/19 at 9:00am.</p> <p>-There was documentation enalapril maleate 20mg was administered on 05/28/19, 05/30/19, and 05/31/19 at 9:00am.</p> <p>-An entry for enalapril maleate 20mg scheduled for administration on 05/28/19 through 05/30/19 at 9:00pm.</p> <p>-There was documentation enalapril maleate 20mg was not administered on 05/28/19 at 9:00pm with the reason documented as "waiting on delivery".</p> <p>-There was documentation enalapril maleate 20mg was not administered on 05/29/19 at 9:00am and 9:00pm with reason documented as "waiting on delivery".</p> <p>-There was documentation enalapril maleate 20mg was not administered on 05/30/19 and 05/31/19 at 9:00pm with the reason documented as "on order."</p> <p>Review of Resident's #4's eMAR for June 2019 revealed:</p> <p>-An entry for enalapril maleate 20mg scheduled for administration on 06/01/19 through 06/05/19 at 9:00am.</p> <p>-There was documentation enalapril maleate</p>	D 358		

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D 358	<p>Continued From page 17</p> <p>20mg was administered on 06/01/19, through 06/05/19 at 9:00am.</p> <p>-An entry for enalapril maleate 20mg scheduled for administration on 06/01/19 through 06/05/19 at 9:00pm</p> <p>-There was documentation enalapril maleate 20mg was not administered on 06/01/19 and 06/02/19 at 9pm with reason documented as "waiting on delivery".</p> <p>-There was documentation enalapril maleate 20mg was not administered on 06/03/19 at 9pm with reason documented as "on order".</p> <p>-There was documentation enalapril maleate 20mg was not administered on 06/04/19 at 9pm with reason documented as "pharmacy notified refill needed, waiting on delivery".</p> <p>-There was documentation enalapril maleate 20mg was not administered on 06/05/19 at 9pm with reason documented as "waiting on delivery".</p> <p>Interview with Medication Aide on 06/18/19 at 3:16pm revealed:</p> <p>-She had contacted the pharmacy about Resident #4's medication needing to be re-ordered.</p> <p>-The pharmacy informed her she needed to contact Resident #4's physician for a new prescription.</p> <p>-Sometimes the physician's office had sent the new prescription to the facility instead of the pharmacy and the facility had sent the new prescription to the pharmacy.</p> <p>-The pharmacy had been "lax" with sending medications to the facility.</p> <p>-Before she had contacted the pharmacy, she had checked overflow to make sure medications had not been placed in overstock.</p> <p>-When medications had been found in overstock, they had to be placed on the medication cart.</p> <p>Interview with Resident Care Coordinator on</p>	D 358		

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D 358	<p>Continued From page 18</p> <p>06/18/19 at 3:00pm revealed:</p> <ul style="list-style-type: none"> <li>-Medication Aides were responsible for ensuring all medications were administered as ordered.</li> <li>-The process for reordering medications was to first check the medication cart and overflow before reordering any medications.</li> <li>-She had checked Resident #4's vitals on 06/05/19, during first shift, and her blood pressure was high, and she proceeded to look for Resident #4's enalapril maleate.</li> <li>-She checked the overflow room and another medication cart and the medication was found.</li> <li>-She had placed the enalapril maleate on the correct cart.</li> <li>-Medication Aides had not thoroughly checked the cart or checked overflow to make sure Resident #4's enalapril maleate was out.</li> </ul> <p>Interview with Health &amp; Wellness Director on 06/18/19 at 2:00pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #4's physician had not been notified that resident had missed her hypertension medication.</li> <li>-She had not been aware Resident #4 enalapril maleate was not on the medication cart.</li> <li>-She had not been aware Resident #4 had not been administered her medication according to the physician's orders.</li> </ul> <p>Refer to review of the Medication Aide Training dated 03/27/19.</p> <p>Attempted telephone interview with the prescribing physician on 06/18/19 and on 06/19/19 at were unsuccessful.</p> <p>Refer to interview on 06/18/19 at 9:16am with the HWD.</p> <p>Refer to interview on 06/19/19 at 10:00am with</p>	D 358		

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D 358	Continued From page 19  the RCC.  Refer to interview on 06/19/19 at 10:30am with the Administrator.  Refer to interview on 06/19/19 at 1:40pm with the Administrator.  Refer to interview on 06/19/19 at 2:20pm with the RCC.  _____  Review of the Medication Aide Training dated 03/27/19 revealed: -There were 8 medication aides (MA) who received the training. -The medications must always be available. -If the medication was running low, the MAs were to re-order. -The MAs were to use the back up pharmacy for after hours/weekends/holidays and document all attempts to get the medications. -If the medication was not available or received at the next delivery, the Health and Wellness Director (HWD) must be notified. -The MAs were responsible to assure the residents received the medications as ordered by the physician. -The MAs were responsible for notification to the HWD, Resident Care Coordinator (RCC) or the Administrator for further instructions if the medication was not on the medication cart. -The MAs were responsible for re-ordering medications that have less than a 7-day supply.  Interview on 06/18/19 at 9:16am with the HWD revealed: -The MAs were responsible for ordering the medications that had 7 days of the medication left or missing from the medication cart.	D 358		

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D 358	<p>Continued From page 20</p> <ul style="list-style-type: none"> <li>-The MAs were responsible for administering medications.</li> <li>-If the medication was not administered for any reason, then the MA would go back to the eMAR and document.</li> <li>-She and the RCC were responsible for weekly medication cart audits and eMAR audits and every medication cart and resident in the facility was to be audited every month.</li> <li>-The last eMAR audits were done the first week of June 2019.</li> <li>-She did not know why the errors were missed.</li> <li>-All MAs were trained 03/27/19 on medication administration, MA responsibilities, and medication policies.</li> </ul> <p>Interview on 06/19/19 at 10:00am with the RCC revealed:</p> <ul style="list-style-type: none"> <li>-She expected the MAs to administer the medications per the policy.</li> <li>-If there was an issue with administering the medication then they were to document the reason.</li> <li>-The MAs were responsible for ordering a medication when there were only 7 days of the medication left in the bubble pack or if the medication was not on the medication cart.</li> <li>-She along with the HWD were responsible for the monthly medication cart audits and if a medication was not in the facility then the medication was ordered from the pharmacy.</li> <li>-She along with the HWD and the Regional RN were responsible for monthly eMAR audits.</li> <li>-The audits were set up so that every medication cart and resident would be audited every month.</li> <li>-She did not know why the medication errors were not found during the audits.</li> </ul> <p>Interview on 06/19/19 at 10:30am with the Administrator revealed:</p>	D 358		

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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE COTSWOLD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3610 RANDOLPH ROAD CHARLOTTE, NC 28211</b>		
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D 358	<p>Continued From page 21</p> <ul style="list-style-type: none"> <li>-The RCC, HWD and Regional RN were responsible for monthly medication cart and eMAR audits.</li> <li>-The eMAR audits consisted of checking for blank documentation, refusals and medications that were not documented as administered.</li> <li>-If there were any of the above issues then the MA involved would be questioned.</li> <li>-She was responsible for weekly meetings with the HWD, RCC and the Regional RN concerning the medication cart and eMAR audits.</li> <li>-She was not aware medications were not re-ordered or missing from the medication carts.</li> <li>-Every resident in the facility was audited monthly.</li> <li>-She expected the audits to be completed and the MAs to give the medications as ordered.</li> <li>-Re-ordering of the medications, administering medications were apart of the MAs daily responsibilities.</li> <li>-The RCC and the HWD were responsible for making sure the MAs kept medication on the medication cart for the residents that had orders for the medications.</li> </ul> <p>Interview on 06/19/19 at 1:40pm with the Administrator, revealed:</p> <ul style="list-style-type: none"> <li>-The HWD, RCC were responsible for putting new orders in the eMAR.</li> <li>-The HWD, RCC and Regional RN were responsible for record audits.</li> <li>-They rotated record audits by floors and spent 2 weeks doing audits on the Assisted Living side, and 2 weeks for the Special Care Unit (SCU) records per month.</li> <li>-The HWD reviewed medications that were in the eMAR.</li> <li>- The Regional RN compared medication orders to the eMARs and to the medications on hand quarterly with the facility's pharmacy provider.</li> <li>-The quarterly audits were last completed on</li> </ul>	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/19/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE COTSWOLD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3610 RANDOLPH ROAD CHARLOTTE, NC 28211</b>
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D 358	<p>Continued From page 22</p> <p>03/18/19 by the Regional RN.</p> <ul style="list-style-type: none"> <li>- "We should never run out of medications ...there was a pharmacy across the street."</li> <li>- The medication aides should not document medication administration if a medication was unavailable.</li> <li>- They should re-order medications 7 days before a medication runs out, when there were 5 days left they should notify the family and the HWD that the refill had not arrived from the pharmacy, if the medication was not in the facility on day three, they should do whatever was necessary to get the medication in the building.</li> <li>- When a medication was missed due to not having it available on the medication cart, the doctor and HWD should be notified whether it was missed one time or multiple times.</li> <li>- The medication aides did not enter orders into the eMAR.</li> <li>- "The MAs used to enter them, but we stopped it."</li> </ul> <p>Interview on 06/19/19 at 2:20pm with the RCC, revealed:</p> <ul style="list-style-type: none"> <li>- She had been the RCC since 05/05/19.</li> <li>- She and the HWD were responsible for entering medication orders into the eMAR.</li> <li>- Once a medication order was entered into the eMAR, the original order was placed in the resident's record.</li> <li>- They used "hot box charting" to keep up with new or changed orders each month.</li> <li>- The night shift MA checked in delivered medications, signed the delivery sheet and placed the medications in the medication cart.</li> <li>- The night shift MAs did not always take out the discontinued or changed medications from the cart.</li> </ul>	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/19/2019</b>
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D 366  D 366	<p>Continued From page 23</p> <p>10A NCAC 13F .1004 (i) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration</p> <p>(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure staff documented the administration of medications immediately following the administration of medications for 2 of 5 sampled residents (Residents #1 and #5) during the morning medication pass on 06/17/19.</p> <p>The findings are:</p> <p>1. Review of Resident #5's current FL2 dated 01/21/19 revealed: -Diagnoses included dementia with behaviors, gastroesophageal reflux disease (GERD), hypertension, edema, depression, gastrointestinal bleed, atrial fibrillation, diverticulitis, anxiety and hyperlipidemia. -A physician's order for buspirone (used to treat major depression) 7.5mg twice daily, Celexa (used to treat depression) 20mg daily, cholecalciferol (used as a supplement) 2000 units daily, clonidine (used to treat high blood pressure)</p>	D 366  D 366	<p>All medication technicians reeducated on medication administration expectations and responsibilities on By HWD and RCC on 6/25/29.</p> <p>QA will include med pass with med techs by HWD or designee to ensure compliance quarterly.</p>	

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D 366	<p>Continued From page 24</p> <p>0.1mg twice daily, docusate sodium (used to treat constipation) 100mg twice daily, Lasix (used to treat edema) 20mg daily, metoprolol tartrate (used to treat high blood pressure) 50mg daily, omeprazole (used to treat GERD) 20mg daily, probiotic (used as a supplement) 1 capsule twice daily, and Xarelto (used to treat deep vein thrombosis) 10mg daily.</p> <p>Review of Resident #5's physician order dated 03/05/19 revealed a subsequent physician's order for ipratropium bromide solution 0.06% 2 sprays in both nostrils two times a day for allergies.</p> <p>Review of Resident #5's physician order dated 06/04/19 revealed a subsequent physician's order for cyanocobalamin 1000mcg by mouth one time a day for B12 deficiency.</p> <p>Review of Resident #5's physician order dated 06/09/19 revealed a subsequent physician's order for Lasix 40mg one time a day for edema.</p> <p>Interview on 06/17/19 at 10:00am with a medication aide (MA) revealed: -She worked first shift on 06/17/19. -She administered the medications to Resident #5 as ordered on 06/17/19. -The policy was to administer the medications within one hour of the scheduled time. -The policy was to compare the medications to be administered in the eMAR with the bubble pack, administer the medications, and then pop the medication, document the medication as administered. -She did not document the medications given at 8:00am and 9:00am because she was "busy with something else".</p> <p>Review of Resident #5's June 2019 electronic</p>	D 366		

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D 366	<p>Continued From page 25</p> <p>medication administration record (eMAR) printed on 06/17/19 at 9:59am revealed:</p> <ul style="list-style-type: none"> <li>-An entry for buspirone 7.5mg twice daily at 8:00am and 8:00pm.</li> <li>-An entry for Celexa 20mg daily at 9:00am.</li> <li>-An entry for cholecalciferol 2000 units daily at 9:00am.</li> <li>-An entry for clonidine 0.1mg twice daily at 8:00am and 8:00pm.</li> <li>-An entry for docusate sodium 100mg twice daily at 8:00am and 8:00pm.</li> <li>-An entry for Lasix 40mg daily at 8:00am.</li> <li>-An entry for metoprolol tartrate 50mg daily at 8:00am.</li> <li>-An entry for omeprazole 20mg daily at 9:00am.</li> <li>-An entry for probiotic 1 capsule twice daily at 8:00am and 8:00pm.</li> <li>-An entry for Xarelto 10mg daily at 8:00am.</li> <li>-An entry for ipratropium bromide solution 0.06% 2 sprays in both nostrils twice daily at 8:00am and 8:00pm.</li> <li>-An entry for cyanocobalamin 1000mcg by mouth daily at 9:00am.</li> <li>-The medications that were scheduled for administration at 8:00am and 9:00am had not been documented as administered by the MA.</li> </ul> <p>Review of the facility's Medication Administration Audit Report printed on 06/19/19 at 9:57am revealed Resident #5's medications that were due to be administered at 8:00am and 9:00am on 06/17/19 were documented with an administration time and documented time of 10:30am on 06/17/19.</p> <p>Refer to review of the Medication Aide Training dated 03/27/19.</p> <p>2. Review of Resident #1's current FL2 dated 10/29/18 revealed diagnoses included acute</p>	D 366		

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D 366	<p>Continued From page 26</p> <p>kidney failure, dementia, hypertension, diabetes and transischemic attack.</p> <p>Review of Resident #1's physician's orders revealed:</p> <ul style="list-style-type: none"> <li>-An order dated 05/31/19 for blood glucose monitoring 4 times a day.</li> <li>-An order dated 05/31/19 for Novolog flex pen sliding scale insulin before meals.</li> <li>-An order dated 05/31/19 for Novolog flex pen 8units before meals.</li> <li>-An order dated 05/31/19 for liothyronine 5mcg every day.</li> <li>-An order dated 05/31/19 for aspirin 81mg every day.</li> <li>-An order dated 05/31/19 for Diltiazem HCl ER beads capsule 360mg every day.</li> <li>-An order dated 05/31/19 for Levemir flex touch pen 30units.</li> </ul> <p>Review of Resident #1's June 2019 electronic medication administration record (eMAR) printed on 06/17/19 at 9:59am revealed:</p> <ul style="list-style-type: none"> <li>-An entry for blood glucose monitoring at 7:30am, 11:30am, 5:30am and 9:00pm.</li> <li>-An entry for Novolog flex pen sliding scale insulin before meals at 7:30am, 11:30am, 5:30pm and 9:00pm.</li> <li>-An entry for Novolog flex pen 8units before meals at 7:30am, 11:30am and 5:30pm.</li> <li>-An entry for liothyronine 5mcg every day at 8:00am.</li> <li>-An entry for aspirin 81mg every day at 8:00am.</li> <li>-An entry for Diltiazem HCl ER beads capsule 360mg every day at 8:00am.</li> <li>-An entry for Levemir flex touch pen 30units 2 times a day at 9:00am and 9:00pm.</li> <li>-An entry for Novolog flex pen 8units before meals at 7:30am, 11:30am and 5:30pm.</li> <li>-The medications that were due at 7:30am,</li> </ul>	D 366		

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D 366	<p>Continued From page 27</p> <p>8:00am, and 9:00am had not been documented as administered by the medication aide (MA).</p> <p>Review of Resident #1's June 2019 electronic medication administration record (eMAR) printed on 06/17/19 at 1:00pm revealed:</p> <ul style="list-style-type: none"> <li>-An entry for blood glucose monitoring at 7:30am, 11:30am, 5:30am and 9:00pm.</li> <li>-An entry for Novoioig flex pen sliding scale insulin before meals at 7:30am, 11:30am, 5:30pm and 9:00pm.</li> <li>-An entry for Novolog flex pen 8units before meals at 7:30am, 11:30am and 5:30pm.</li> <li>-An entry for Novolog flex pen 8units before meals at 7:30am, 11:30am and 5:30pm.</li> <li>-The medications that were due at 11:30am had not been documented as administered by the MA.</li> </ul> <p>Review of the facility's Medication Administration Audit Report printed on 06/19/19 at 9:57am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #5's medications that were due to be administered at 7:30am on 06/17/19 were documented with an administration time and documented time of 11:00am and 11:01am on 06/17/19.</li> <li>-Resident #5's medications that were due to be administered at 8:00am and 9:00am on 06/17/19 were documented with an administration time and documented time of 10:29am on 06/17/19.</li> <li>-Resident #5's medications that were due to be administered at 11:30am on 06/17/19 were documented with an administration time and documented time of 1:11pm on 06/17/19.</li> </ul> <p>Interview with a MA on 06/17/19 at 10:00am revealed:</p> <ul style="list-style-type: none"> <li>-She worked first shift on 06/17/19.</li> <li>-She administered the medications to Resident #1 as ordered on 06/17/19.</li> </ul>	D 366		

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D 366	<p>Continued From page 28</p> <ul style="list-style-type: none"> <li>-The policy was to administer the medications within one hour of the scheduled time.</li> <li>-The policy was to administer and document the medication after administration.</li> <li>-She did not always document the medications as administered per the facility policy.</li> <li>-She did not document the medications given at 7:30am, 8:00am and 9:00am because she was busy with something else.</li> </ul> <p>Interview with the Health and Wellness Director (HWD) on 06/18/19 at 9:16am revealed:</p> <ul style="list-style-type: none"> <li>-The MAs were to administer all medications within an hour of the administration time on the eMAR.</li> <li>-The MAs were responsible for administering medications.</li> <li>-The policy was to administer the medication after document the medication</li> <li>-If the medication was not administered for any reason, then the MA would go back to the eMAR and make a note.</li> <li>-All MAs were trained 03/27/19 on medication administration, MA responsibilities, and medication policies with one exception to administer the medication after documentation instead of administering the medication and then documentation.</li> </ul> <p>Interview with the Resident Care Coordinator (RCC) on 06/19/19 at 10:00am revealed:</p> <ul style="list-style-type: none"> <li>-She expected the MAs to give the medications per the policy, document and administer the medication to the correct resident within an hour of the administration time on the eMAR.</li> <li>-If there was an issue with administering the medication then come back and document the reason.</li> </ul> <p>Interview with the Administrator on 06/19/19 at</p>	D 366		

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D 366	<p>Continued From page 29</p> <p>10:30am revealed:</p> <ul style="list-style-type: none"> <li>-The RCC, HWD and Regional RN were responsible for monthly eMAR audits.</li> <li>-The eMAR audits consisted of checking for blank documentation, refusals and medications that were not documented as administered including within an hour of the administration time on the eMAR.</li> <li>-If there were any of the above issues then the MA involved would be questioned.</li> <li>-She was responsible for weekly meetings with the HWD, RCC and the Regional RN concerning the eMAR audits.</li> <li>-Every resident's eMAR was audited monthly.</li> <li>-She expected the audits to be completed and the MAs to give the medications as ordered to the correct resident and at the correct time.</li> </ul> <p>Refer to review of the Medication Aide Training dated 03/27/19.</p> <hr/> <p>Review of the Medication Aide Training dated 03/27/19 revealed:</p> <ul style="list-style-type: none"> <li>-There were 8 medication aides (MA) who received the training.</li> <li>-The MAs were responsible to assure the residents received the medications as ordered by the physician.</li> <li>-The MAs were responsible for the 7 Rights of Medication Administration; the right medication, the right dose, the right time, the right route, the right resident, the right documentation and the right to refuse.</li> <li>-The MAs were responsible for the documentation of the medication promptly after the resident has taken the medication.</li> </ul>	D 366		

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D 367	Continued From page 30	D 367	D367 – Medication Administration  All medication technicians reeducated on medication administration expectations and responsibilities on By HWD and RCC on 6/25/29.  QA will include med pass with med techs by HWD or designee to ensure compliance quarterly.	
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 documented and maintained with the medication administration record (MAR).  This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure medication administration records (MARs) were accurate for 2 of 5 sampled residents (#1 & #4) related to a thyroid medication (#1) and a medication for hypertension (#4).	D 367		

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D 367	<p>Continued From page 31</p> <p>1. Review of Resident #1's current FL2 dated 10/29/18 revealed diagnoses included acute kidney failure, dementia, hypertension, diabetes and transischemic attack.</p> <p>Review of Resident #1's physician's orders revealed an order dated 11/13/18 for levothyroxine sodium 50mcg every day.</p> <p>Review of Resident #1's May 2019 eMAR revealed:</p> <ul style="list-style-type: none"> <li>-An entry for levothyroxine sodium 50mcg every morning documented as administered 05/01/19 at 7:00am - 05/07/19 at 7:00am, every day.</li> <li>-An entry for levothyroxine sodium 50mcg every morning documented as not administered 05/08/19 at 7:00am - 05/11/19 at 7:00am, every day.</li> <li>-An entry for levothyroxine sodium 50mcg every morning documented as administered 05/12/19 at 7:00am.</li> <li>-An entry for levothyroxine sodium 50mcg every morning documented as not administered 05/13/19 at 7:00am - 05/15/19 at 7:00am, every day.</li> <li>-An entry for levothyroxine sodium 50mcg every morning documented as administered 05/16/19 at 7:00am - 05/31/19 at 7:00am, every day.</li> <li>-There was no documentation to justify the levothyroxine sodium 50mg not being administered 05/08/19 through 05/11/19 and 05/13/19 through 05/15/19 at 7:00am.</li> </ul> <p>Review of the Medication Aide Training dated 03/27/19 revealed:</p> <ul style="list-style-type: none"> <li>-There were 8 medication aides (MA) received the training.</li> <li>-The MAs were responsible to assure the residents received the medications as ordered by the physician.</li> </ul>	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/19/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE COTSWOLD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3610 RANDOLPH ROAD</b> <b>CHARLOTTE, NC 28211</b>		
(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	<p>Continued From page 32</p> <ul style="list-style-type: none"> <li>-The MAs were responsible for the 7 Rights of Medication Administration; the right medication, the right dose, the right time, the right route, the right resident, the right documentation and the right to refuse.</li> <li>-The MAs were responsible for the documentation of the medication promptly after the resident has taken the medication.</li> </ul> <p>Interview with a MA on 06/17/19 at 11:08am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 was out of her levothyroxine sodium 50mcg every day from 05/08/19 - 05/15/19 per the Nurses notes.</li> <li>-She must have accidentally documented the levothyroxine sodium 50mcg every day as administered.</li> </ul> <p>Interview with the Health and Wellness Director (HWD) on 06/18/19 at 9:16am revealed:</p> <ul style="list-style-type: none"> <li>-The MAs were responsible for documenting the medications as administered after popping out the medication out of the bubble pack.</li> <li>-All MAs were trained 03/27/19 on medication administration, MA responsibilities, and medication policies.</li> <li>-The MAs should not document a medication as administered if it was not in the facility.</li> </ul> <p>Interview with the Resident Care Coordinator (RCC) on 06/19/19 at 10:00am revealed:</p> <ul style="list-style-type: none"> <li>-The MAs were responsible for documenting the medications as administered after popping out the medication out of the bubble pack.</li> <li>-All MAs were trained 03/27/19 on medication administration, MA responsibilities, and medication policies.</li> <li>-It was not the policy to document a medication that was not in the facility.</li> </ul>	D 367		

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D 367	<p>Continued From page 33</p> <p>Refer to interview with the Administrator on 06/19/19 at 2:00pm.</p> <p>2. Review of Resident #4's current FL2 dated 01/31/19 revealed: -Diagnoses included hypertension, history of hypo-osmolarity, spinal stenosis and osteoarthritis. -A physician order for enalapril maleate 20mg (to treat hypertension) one tablet two times a day.</p> <p>Review of Resident's #4's May 2019 eMAR revealed: -An entry for enalapril maleate 20mg 1 tablet two times daily at 9:00am and 9:00pm. -Enalapril maleate 20mg 1 tablet two times daily was documented as being administered 05/01/19 at 9:00am to 05/28/19 at 9:00am. -On 05/29/19 enalapril maleate 20mg was documented as not administered at 9:00am and 9:00pm. -On 05/30/19 through 05/31/19 enalapril maleate 20mg was documented as administered at 9:00am. -On 05/30/19 through 05/31/19 enalapril maleate 20mg was documented as not administered at 9:00pm. -On 05/31/19 enalapril maleate 20mg was documented as administered at 9:00am. -On 05/31/19 enalapril maleate 20mg was documented as not administered at 9:00pm.</p> <p>Review of Resident's #4's June 2019 eMAR revealed: -An entry for enalapril maleate 20mg 1 tablet two times daily at 9:00am and 9:00pm. -On 06/01/19 through 06/05/19 enalapril maleate 20mg was documented as administered at 9:00am. -On 06/01/19 through 06/05/19 enalapril maleate</p>	D 367		

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D 367	<p>Continued From page 34</p> <p>20mg was documented as not administered at 9:00pm.</p> <p>Interview with the medication aide (MA) on 06/18/19 at 3:16pm revealed:</p> <ul style="list-style-type: none"> <li>-She had contacted the pharmacy about Resident #4's medication needing to be re-ordered.</li> <li>-She had checked the overstock to make sure the medication was not there before she had contacted the pharmacy.</li> <li>-If medications had been in overstock, they were to be placed on the medication cart.</li> <li>-The pharmacy informed her she needed to contact Resident #4's physician for a new prescription.</li> <li>-She stated sometimes doctor's offices sent the new prescription to the facility instead of the pharmacy and the facility would send the new prescription to the pharmacy.</li> <li>-Sometimes the pharmacy was "lax" when sending medications to the facility.</li> <li>-At times MAs documented on the eMAR a medication not administered without looking for the medication.</li> </ul> <p>Interview with Health &amp; Wellness Director on 06/18/19 at 10:55am revealed:</p> <ul style="list-style-type: none"> <li>-She did not know why some MAs had documented the medication had been administered to a resident and why some had documented not administering the medication.</li> <li>-All MAs were trained 03/27/19 on medication administration, MA responsibilities, and medication policies with one exception to administer the medication after documentation instead of administering the medication and then documentation.</li> <li>-She did not know Resident #4 enalapril maleate was not on the medication cart.</li> <li>-She did not know Resident #4's eMARs had</li> </ul>	D 367		

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D 367	Continued From page 35  been documented inaccurately. -She audited MARs when she had time. -She shared the responsible of weekly medication cart audits and eMAR audits with the RCC.  Refer to interview with the Administrator on 06/19/19 at 2:00pm.  _____  Interview with the Administrator on 06/19/19 at 2:00pm revealed: -The MAs were responsible for documenting the medication that were administered. -The eMAR should reflect the correct documentation of the medications as administered, refused, or the medication was not available and the reason. -She did not know a medication was documented as administered when the medication was also documented as "on order".	D 367		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train  10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training  The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each	D 468	D468  New mandatory training software will be in place by 8/30/19 to include 20-hour training specific to special care unit and 6-hour training during orientation.  Administrator or designee will audit for compliance monthly for next 90 days and quarterly moving forward.	

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D 468	<p>Continued From page 36</p> <p>employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents.</p> <p>(3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.</p> <p>(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure staff assigned to the memory care unit had completed 6 hours of orientation during the first week of employment and 20 hours of training within six months of employment specific to the population being served for 4 of 4 special care unit (SCU) staff. (Staff C, D, E, and F).</p> <p>The findings are:</p> <p>1. Review of the staff record for Staff C revealed: -The hire date for Staff C by a temporary staffing agency was 07/05/16. -Staff C had began working on the SCU as temporary third shift medication aide (MA) on 05/13/19. -There was documentation of 2 hours of SCU training completed on 12/01/17. -There was no additional documentation of SCU training within the first six months of hire.</p>	D 468		

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D 468	Continued From page 37  Telephone interview with the temporary staffing agency on 06/19/19 at 2:45pm revealed: -Staff C had been hired by the staffing agency on 07/05/16 as a MA. -The staffing agency signed a contract with the facility for temporary staffing of Staff C on 05/07/19. -Staff C had been working as a MA as needed on third shift since 05/17/19. -They had sent all records of Staff C's SCU training on 05/07/19.  Attempted telephone interview with Staff C on 06/19/19 at 3:00pm was unsuccessful.  Refer to interview with the Business Office Manager (BOM) on 06/19/19 at 11:30am.  Refer to interview with the Memory Care Coordinator (SCC) on 06/19/19 at 11:42am.  Refer to interview with the Administrator on 06/19/19 at 3:58pm. 2. Review of the staff record for Staff D revealed: -Staff D was hired on 10/10/18 to work in the SCU, as a personal care aide (PCA)/medication aide (MA). -There was documentation of 8 hours of SCU training completion on 10/26/18. -There was documentation of 9 hours of SCU training completion within six months of employment. -There was no additional documentation of SCU training.  Interview with Staff D on 06/19/19 at 11:45am revealed: -She completed SCU training during her first week of hire.	D 468		

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D 468	<p>Continued From page 38</p> <ul style="list-style-type: none"> <li>-She completed some additional training online and in-person since being hired.</li> <li>-She did not know if she had completed an additional 20 hours of training within six months of being hired.</li> </ul> <p>Refer to interview with the Business Office Manager (BOM) on 06/19/19 at 11:30am.</p> <p>Refer to interview with the Memory Care Coordinator (MCC) on 06/19/19 at 11:42am.</p> <p>Refer to interview with the Administrator on 06/19/19 at 3:58pm.</p> <p>3. Review of the staff record for Staff E revealed:</p> <ul style="list-style-type: none"> <li>-Staff E was hired on 01/22/18 to work in the special care unit (SCU), as a personal care aide (PCA).</li> <li>-There was documentation of 8 hours of SCU training completion on 02/02/19.</li> <li>-There was documentation of 6 hours of SCU training completion within six months of employment.</li> <li>-There was no additional documentation of SCU training.</li> </ul> <p>Interview with Staff E on 06/19/19 at 11:40am revealed:</p> <ul style="list-style-type: none"> <li>-She completed SCU training during her first week of hire with the Memory Care Coordinator (MCC).</li> <li>-She had completed additional online and in-person related to dementia since completing her first week of training.</li> <li>-She did not know if she had completed an additional 20 hours of training within six months of being hired.</li> </ul> <p>Refer to interview with the Business Office</p>	D 468		

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D 468	<p>Continued From page 39</p> <p>Manager (BOM) on 06/19/19 at 11:30am.</p> <p>Refer to interview with the Memory Care Coordinator (MCC) on 06/19/19 at 11:42am.</p> <p>Refer to interview with the Administrator on 06/19/19 at 3:58pm.</p> <p>4. Review of the staff record for Staff F revealed: -Staff F was hired on 08/22/18 to work in the special care unit (SCU), as a personal care aide (PCA). -There was documentation of 8 hours of SCU training completion dated 09/21/18. -There was documentation of 4.5 hours of SCU training completion dated 05/22/19. -There was no additional documentation of SCU training.</p> <p>Attempted telephone interview with Staff F on 06/19/19 at 1:47pm was unsuccessful.</p> <p>Refer to interview with the Business Office Manager (BOM) on 06/19/19 at 11:30am.</p> <p>Refer to interview with the Memory Care Coordinator (MCC) on 06/19/19 at 11:42am.</p> <p>Refer to interview with the Administrator on 06/19/19 at 3:58pm.</p> <p>Interview with the Business Office Manager (BOM) on 06/19/19 at 11:30am revealed: -She was responsible for maintaining staff personnel records. -She was informed by management that the memory care staff needed to have eight hours of memory care training within the first week and 16 hours of training completed on the second week of hire.</p>	D 468		

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D 468	<p>Continued From page 40</p> <p>-She began working as the BOM April 2019 and had not had a chance to audit staff records for memory care training.</p> <p>-She did not know sampled staff did not have the additional 20 hours of training in their staff records.</p> <p>Interview with the Memory Care Coordinator on 06/19/19 at 11:42am revealed:</p> <p>-He did not know staff working in memory care needed to have 20 hours of additional memory care training within the first 6 months of hire.</p> <p>-He was responsible for completing memory care training with the staff who worked in the MCU.</p> <p>Interview with the Administrator on 06/19/19 at 3:58pm revealed:</p> <p>-She thought the registered nurse (RN) in the MCU completed the 20 hours of MCU training with Staff C, D, E, and F.</p> <p>-The RN was no longer working at the facility and her training records could not be obtained.</p> <p>-She did not know the additional 20 hours of memory care training was not completed.</p> <p>- "We need a better way of keeping track of the additional 20 hours of memory care training".</p>	D 468	D935	
D935	<p>G.S. § 131D-4.5B(b) ACH Medication Aides; Training and Competency</p> <p>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.</p> <p>(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in</p>	D935	<p>BOC will ensure that appropriate documentation is in associate file for each discipline.</p> <p>BOC to audit files for compliance within 30 days and will audit 10% of employee files for compliance quarterly.</p>	

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D935	<p>Continued From page 41</p> <p>an adult care home or successfully completed all of the following:</p> <p>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ul style="list-style-type: none"> <li>a. The key principles of medication administration.</li> <li>b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.</li> </ul> <p>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.</p> <p>(3) Within 60 days from the date of hire, the individual must have completed the following:</p> <ul style="list-style-type: none"> <li>a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: <ul style="list-style-type: none"> <li>1. The key principles of medication administration.</li> <li>2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.</li> </ul> </li> <li>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.</li> </ul> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the</p>	D935		
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D935	<p>Continued From page 42</p> <p>facility failed to ensure 1 of 5 sampled medication aides (Staff C) had completed her 15 hours state approved medication training or had a medication aide(MA) employment verification form.</p> <p>The findings are:</p> <p>Review of the staff record for Staff C, medication aide (MA), revealed:</p> <ul style="list-style-type: none"> <li>-The hire date for Staff C by a temporary staffing agency was 07/05/16.</li> <li>-There was documentation Staff C had successfully completed the medication exam on 10/27/15.</li> <li>-The Medication Administration Clinical Skill Checklist was completed on 05/13/19.</li> <li>-There was no documentation of the 15 hours of required state approved medication training.</li> </ul> <p>Review of the staffing schedule for 06/18/19 and 06/19/19 revealed Staff C was scheduled as a third shift MA.</p> <p>Telephone interview with the temporary staffing agency on 06/19/19 at 2:45pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff C had been hired by the staffing agency on 07/05/16 as a MA.</li> <li>-The staffing agency signed a contract with the facility for temporary staffing of Staff C on 05/07/19.</li> <li>-Staff C had been working as a MA at this facility as needed on third shift since 05/17/19.</li> <li>-They used the Medication Administration 10- and 15-hour training course manual material to conduct their trainings.</li> <li>-They did not have documentation Staff C had completed the medication training hours.</li> <li>-They had not sent a MA employment verification form.</li> </ul>	D935		
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE COTSWOLD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3610 RANDOLPH ROAD</b> <b>CHARLOTTE, NC 28211</b>		
(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
D935	<p>Continued From page 43</p> <p>Interview with the Business Office Manager (BOM) on 06/19/19 at 9:00 am revealed: -Staff C had begun working on 05/17/19 after a temporary staffing contract was signed with a temporary staffing agency. -Since she had started working as the BOM in April 2019 she had not audited the staff records to ensure all the staff had completed the required 15 hours of Medication Training hours. -She was not aware Staff C did not have the required 15 hours of Medication Training hours or a MA employment verification form.</p> <p>Interview with the Administrator on 06/19/19 at 2:30pm revealed: -Staff C was from a temporary staffing agency. -She did not know Staff C did not have documentation of 15 hours of Medication Training hours. -She had not reviewed Staff C's staff record to ensure the documentation of 15 hours of Medication Training hours had been completed. -She had not asked the temporary staffing agency for a MA employment verification form to be completed.</p> <p>Attempted telephone interview with Staff C on 06/19/19 at 3:00pm was unsuccessful.</p>	D935		