Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032065	A. BUILDING: _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DURHAM	4434 BEN FRANKLIN BOULEVARD DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 07/09/19 to 07/11/19.	D 000		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; 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 the facility was maintained without chronic odors of urine. Observation on 07/09/19 at 3:47 pm revealed resident room #101 had a urine odor coming from the room into the hall on the first floor. Attempted interview with resident that resided in room #101 on 07/09/19 at 3:47 pm was unsuccessful. Observation on 07/10/19 at 6:29 am revealed room #101 had a strong urine odor coming from the room into the hallway. Interview with the Medication Aide (MA) on 07/10/19 at 6:42 am revealed: -Room #101 had urine on bathroom floor and she covered the urine with a mattress pad. -Room #101 needed the bathroom floor cleaned because the resident who resided in the room urinated a lot on the floor.	D 075		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Executive Director (X6) DATE 8/21/19

I have reviewed and accepted. 08/26/19

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D 075	Continued From page 1 Observation on 07/10/19 at 6:45 am revealed the MA placed a disposable mattress pad on bathroom floor in room #101 to cover urine. Interview with the housekeeper on 07/10/19 at 7:45 am revealed: -There was always a urine odor in room #101. -Staff would notify housekeeping when resident that resided in room #101 urinated on the bathroom floor to have it cleaned. -She scrubbed the bathroom floor daily. - "The odor could be coming from his carpet because the odor is still there after I clean." Interview with a personal care aide on 07/10/19 at 10:21 am revealed: -The urine odor was not the resident; the odor is in the room. -The bathroom tile in room #101 had been removed; not sure of date. Interview with the Health and Wellness Director on 07/10/19 at 11:04 am revealed: -The carpet in room #101 was cleaned in June 2019 due to the urine odor in the room. -The resident in room #101 did not wet the bed and there is no urine odor in the bed mattress nor the recliner chair. -The recliner in room #101 does not have an odor. Interview with the Executive Director on 07/10/19 at 5:18 pm revealed: -She planned to speak with the resident's son about possible options to alleviate odor. -The maintenance director was looking for a product to eliminate urine odor.	D 075		

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D 113	Continued From page 2	D 113		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to assure the water temperatures at 8 of 8 fixtures (sinks and showers on three different floors) used by the residents in 9 of 9 resident rooms and 1 of 3 common bathroom/spa were maintained between 100-116 degrees Fahrenheit (F). The findings are: Observation of resident room #307 on 07/09/19 at 9:50 am revealed the hot water termperature at the sink was 98 degrees Fahrenheit (F). Observation of resident room #221 on 07/09/19 at 9:55 am revealed the hot water temperature at the sink was 99.0 degrees F. Observation of resident room #306 on 07/09/19 at 10:05 am revealed: -The hot water temperature at the sink was 98.0 degrees F. -The hot water temperature at the shower was 78.0 degrees F.	D 113		

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D 113	Continued From page 3 Observation of resident room #225 at 10:30 am revealed the hot water temperature at the sink was 95.0 degrees F. Observation of resident room #319 on 07/09/19 at 10:23 am revealed the hot water temperature at the shower was 97.6 degrees F. Interview with resident who resided in room #319 on 07/09/19 at 10:25 am revealed: -The water took a long time to warm up, but the water did warm up. -She had not told anyone about the length of time it took for the water to warm. Observation of resident room #321 shower on 07/09/19 at 10:30 am revealed: -The hot water temperature at the shower was 97.1 degrees F. -The hot water temperature at the sink was 99.3 degrees F. Interview with resident who resided in room #321 on 07/09/19 at 10:25 am revealed the water became warm after it ran for several minutes. Observation of resident room #324 shower on 07/09/19 at 1:38 pm revealed the hot water temperature at the shower was 82 degrees F. Observation of resident room #325 shower on 07/09/19 at 10:47 am revealed: -The hot water temperature at the sink was 98.1 degrees F. -The hot water temperature at the shower was 78.5 degrees F. Interview with resident who resided in room #325 on 07/09/19 at 10:35 am revealed:	D 113		

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-She had noticed problems with the hot water temperature.
-She had not showered in two weeks because the water in the shower would not warm.
-She told a "young man" in maintenance about the hot water issue approximately a week ago.
-She told a family member about the hot water temperature, but she did not know if he had spoken with the Administrator.

Observation of resident room #108 sink on 07/09/19 at 11:10 am revealed the hot water temperature was 99.9 degrees F.

Interview with the Maintenance Director (MD) on 07/09/19 at 2:30 pm revealed:
-He knew about the low water temperature in some of the resident rooms.
-A water temperature log was maintained for the facility by his department.
-The maintenance staff who worked with him tested water temperatures throughout the facility once a week.
-The facility had placed a bid for the repair of the main mixing valve on 07/01/19 but it had not been repaired yet.
-He called the repairman on 07/08/19 and left a message to schedule the repair but had not heard back from the repairman.
-The fixture valve was broken in resident room #325 and he was able to repair it this afternoon.
-He did not know the about the broken fixture valve in resident #325 until 07/09/19 because no one had reported it to him.
-The water temperature should be between 100 and 116 degrees F.

Recheck of hot water temperature in resident room #325 with the MD on 07/09/19 at 2:41 pm revealed the hot water temperature at the shower

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was 78.4 degrees F on the MD's thermometer.

Recheck of hot water temperature of resident room #325 on 07/10/19 at 9:00 am revealed the hot water temperature at the shower was 99 degrees F.

Recheck of resident room #306 on 07/10/19 at 2:32 pm revealed the hot water temperature at the shower was 101 degrees F.

Interview with the medication aide (MA) on 07/10/19 at 2:15 pm revealed none of the residents had complained about the water temperature.

Recheck of hot water temperature in resident room #325 on 07/11/19 at 1:10 pm with the maintenance person revealed the hot water temperature at the shower was 78.4 with the maintenance director's thermometer.

Interview with the maintenance staff on 07/11/19 at 1:15 pm revealed:
-The maintenance department was aware of the low hot water temperatures throughout the facility.
-The facility needed a new mixing valve and the facility was approved to have a new mixing valve installed.
-He did not know when the mixing valve would be installed but the MD had called the company who would install the mixing valve to set a date.
-He tested the hot water temperature daily by picking various places throughout the building and documented the temperatures on the water temperature logs.
-He was told about hot water temperature problems in room #325 last week by a personal care aide (PCA).
-He told her to use the common bathroom/spa on

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the second floor to bathe residents in while waiting for the mixing valve to be repaired.
-He did not know if the fixture valve in room #325 was repaired or not.
-The common bathroom/spa on the third floor was not available because it was being renovated and had an out of order sign on the door.

Recheck of hot water temperature in resident room #325 on 07/11/19 at 1:30 pm revaled the hot water temperature at the shower was 98 degrees F and at the sink the hot water temperature was 96 degrees F.

Observation of the second floor common bathroom/spa on 07/11/19 at 1:25 pm with the maintenance person revealed the hot water temperature at the shower was 75.4 degrees F.

Interview with the maintenance staff on 07/11/19 at 1:26 pm revealed:
-He did not know the hot water temperature was low at the shower for the second floor common bathroom/spa.
-He thought the problem was the facility's mixing valve.
-He tried to make daily adjustments to the system to allow the hot water temperature to increase.

Review of the water temperature logs revealed:
-There was no documentation of water temperatures for July 2019.
-There was documentation of water temperatures for the dates June 4, 5, and 7 (there was no documentation of the year).
-The water temperature documented for June 4 was 112.4 in room #117.
-The water temperatures documented for June 5 was 116.6 in room #321 and 116.5 in room #224.
-The water temperature documented for June 7

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D 113	Continued From page 7 was 113.1 in room #226. -There were water temperatures documented for various resident rooms in April and May without documentation of the year only the day. Attempted interview with the MD on 07/11/19 at 2:00 pm was unsuccessful. Interview with the Executive Director on 07/11/19 at 3:05 pm revealed: -The MD kept a water temperature log and he was responsible for ensuring the hot water temperature was maintained within the required range. -She knew that there were problems with the hot water temperature and a request for a new mixing valve was made and approved on 07/01/19. -She and the MD had contacted the repair company on 07/09/19 and 07/11/19 to set a date for the repair. -The repair company called back on 07/11/19 but she nor the MD were able to speak with them and had to call them back to set a date for the repair.	D 113		
D 235	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental	D 235		

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Retardation Services, which shall comply with the following:

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure 3 of 9 sampled residents (#4, #6, #9) had a medical examination recorded on the FL-2 form signed by the primary care provider. The findings are:

1. Review of Resident #4's previous FL-2 dated 06/11/18 revealed:
-Diagnoses included syncope and collapse, type 2 diabetes mellitus, Alzheimer's disease, essential hypertension and muscle weakness.
-The FL2 included a diet order and medication orders.

Review of a Resident Register for Resident #4 revealed the resident was admitted on 07/11/2016.

Review of Resident #4's primary care provider (PCP) subsequent orders revealed:
-There was an order dated 06/15/18 for Lexapro (an antidepressant) 5mg daily that was not on the FL-2 dated 06/11/18.
-There was an order dated 10/12/18 for fasting blood sugars twice a week and start glipizide (medication used to lower glucose) 5mg each morning; neither order was on the FL-2 dated 06/11/18.
-There were no additional orders for Resident #4.

Interview with the Health and Wellness Coordinator (Licensed Practical Nurse) on 07/09/19 at 2:30pm revealed:
-The previous Health and Wellness Coordinator faxed the FL-2 to the PCP before she resigned in May 2019.

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-She had since refaxed Resident #4's FL-2 for signature to the PCP, "probably" the second week of June 2019.
-The FL-2 was faxed to the PCP because Resident #4's PCP was an outside provider meaning she did not see the facility's contracted provider.
-She was not sure if she had a copy of the fax confirmation or documentation of the date she faxed the FL-2, but she would check.

Interview with the Health and Wellness Director (Registered Nurse) on 07/09/19 at 5:00pm revealed:
-The previous Health and Wellness Coordinator had faxed it prior to her last day of work.
-Resident #4's PCP was an outside provider, and she would ask the resident's family member to take the FL-2 to the PCP's office for signature.

Based on record reviews, no additional documentation regarding Resident #4's FL-2 was provided.

Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.

Attempted interview with Resident #4's PCP on 07/10/19 was unsuccessful.

Refer to interview with the Health and Wellness Director on 07/09/19 at 5:00pm.

Refer to interview with the Executive Director on 07/11/19 at 12:54pm.

2. Review of Resident #6's most recent FL-2 dated 06/18/18 revealed diagnoses included Alzheimer's, major depressive disorder,

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glaucoma, age-related osteoporosis, and gastroesophageal reflux disease.

Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 11/12/15.

Review of Resident #6's record revealed:
-There was not an FL-2 dated after 06/18/18.
-There was a "Physician's Orders" medication list from the pharmacy that was signed and dated by Resident #6's Primary Care Provider (PCP) on 03/14/19.

Interview with the Health and Wellness Director on 07/09/19 at 2:30pm revealed:
-Resident #6 had an in-patient hospital stay in 12/2018.
-She thought Resident #6 had a new FL-2 from the hospitalization.
-She would have to locate the current FL-2.

Second interview with the Health and Wellness Director on 07/10/19 at 4:51pm revealed she had not located a current FL-2 for Resident #6.

Based on observations, interviews and record reviews it was determined Resident #6 was not interviewable.

Refer to interview with the Health and Wellness Director on 07/09/19 at 5:00pm.

Refer to interview with the Executive Director on 07/11/19 at 12:54pm.

3. Review of Resident #9's current FL-2 dated 02/17/17 revealed diagnoses included right

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bundle branch block, breast cancer, lower extremity edema, gastro-esophageal reflux disease, and hip fracture.

Review of Resident #9's Resident Register revealed Resident #9 was admitted on 04/21/14.

Review of Resident #9's pharmacy review notes revealed:
-There was a note dated 10/31/18 that indicated Resident #9's FL-2 was sent to be signed by the physician.
-There was a note dated 04/30/19 that indicated Resident #9's FL-2 was dated 04/06/16.

Review of Resident #9's record revealed there were no FL-2s dated after 02/12/17 and there was an FL-2 dated 04/06/16.

Based on record reviews, no other documentation regarding Resident #9 was provided.

Refer to interview with the Health and Wellness Director on 07/09/19 at 5:00 pm.

Refer to interview with the Executive Director on 07/11/19 at 12:54 pm.

_____

Interview with the Health and Wellness Director on 07/09/19 at 5:00pm revealed:
-The nurses (Health and Wellness Director or Health and Wellness Coordinator) were responsible for ensuring FL-2s were completed annually and upon admission.
-The current Health and Wellness Coordinator had been trying to go through a lot of paperwork to determine what needed completing.
-Staff know what orders to follow based on physician order sheets and any subsequent orders; without any updated orders, staff go by

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D 235	Continued From page 12 the last FL-2. Interview with the Executive Director on 07/11/19 at 12:54pm revealed: -She was not aware there were outdated FL-2s. -The nurses were responsible for ensuring the FL-2s were updated and completed annually for current residents.	D 235		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure physician orders were implemented for 1 of 7 sampled residents (Resident #5) with an order for weekly weights. The findings are: Review of Resident #5's current FL-2 dated 04/04/19 revealed:	D 276		

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D 276	Continued From page 13 -Diagnoses included heart failure, muscle weakness, chronic fatigue, and mild cognitive impairment. -There was documentation the resident needed weights done weekly. Review of the Resident #5's May 2019 electronic medication administration records (eMARs) revealed 3 out 4 weekly weights were documented. Review of the Resident #5's June 2019 electronic medication administration records (eMARs) revealed 2 out 4 weekly weights were documented. Review of the facility's personal care documentation (electronic clinical weights and vitals) for Resident #5 revealed there was only one entry per month for the resident's weight in May, June and July 2019. Interview with the medication aide (MA) on 07/09/19 at 2:50 pm revealed: -The weekly weights for Resident #5 did not "pop up on eMAR." -The weights for residents in the facility were done by either a personal care aide (PCA) or MA. -She was not aware Resident #5 was to be weighed weekly. Interview with a PCA on 07/09/19 at 3:28 pm revealed: -The weights for residents in the facility were done on the first of the month in the mornings. -"If resident needed to be weighed weekly it would be discussed in stand-up meeting." -She was not aware resident #5 was to be weighted weekly.	D 276		

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D 276	Continued From page 14 Interview with a second MA on 07/09/19 at 3:34 pm revealed the physician's order for weekly weights for Resident #5 were not put into the computer system. Interview with a third MA on 07/09/19 at 3:53 pm revealed: -The MAs, Health and Wellness Director (HWD) and or PCAs were responsible for putting physician orders into the computer (eMAR). -The original physician's order would be placed into the resident's chart. Interview with a fourth MA on 07/10/19 at 6:32 am revealed: -She was aware Resident #5 needed weekly weights. -She did not have time to weigh Resident #5 in the mornings. -"I let the med tech on first shift know they have to do his weight." -"I don't know why they schedule his weight at 6:00 am." -She had not made anyone aware the time ordered for Resident #5's weekly weights needed to be changed. Interview with the HWD on 07/10/19 at 7:38 am revealed: -She and MAs were responsible for putting physician orders into computer system. -If Resident #5 was not weighed at 6:00 am then first shift would need to weigh him. -The MA or PCA should notify the HWD if residents were not being weighed as ordered. -She was not aware Resident #5 needed to be weighed weekly.	D 276		

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D 282	Continued From page 15	D 282		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination related to a build-up of a black substance in the ice machine, a black and white build-up on the shelves in the walk-in refrigerator, a build-up of a black substance on the interior of a food/utility cart, a black and brown greasy film covering the back wall of the dish area, a thick layer of dust build-up on the ceiling vents in the dish area and food items stored in the refrigerator and the dry pantry that were not dated or labeled. Observation of the kitchen and dish area on 07/10/19 at 8:34am revealed: -There was a build-up of a black substance on the interior of a food/utility cart. -There was a black and brown greasy film covering the back wall of the dish area. -There was a thick layer of dust build-up on the ceiling vents in the dish area. -There was cereal that had been poured into two plastic bins without a date and label. Obervation of the walk-in refrigerator on 07/10/19 at 9:09am -There was a dried white residue and a black build-up on the shelves in the walk-in refrigerator.	D 282		

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D 282	Continued From page 16 -There was a sheet rack with two loaves of raw meat covered with plastic that were not dated and labeled. Interview with a dietary staff on 07/10/19 at 9:33am revealed: -The servers washed the food/utility carts after each use. -She cleaned the food/utility carts with sanitizer and then wiped down. Observation of the ice machine on 07/10/19 at 9:40am revealed the ice machine had black and brown substance build up inside the machine. Interview with the Kitchen Manager (KM) on 07/10/19 at 9:42am revealed: -She assigned the daily cleaning tasks for the staff. -The cleaning schedule listed the items that were cleaned daily and weekly. -The servers were responsible for cleaning and sanitizing the dish area. -The cooks were responsible for cleaning and sanitizing the walk-in refrigerator. -She cleaned the ice machine monthly. -The ice machine was last cleaned on 06/12/19. Interview with the Executive Director on 07/11/19 at 9:00am revealed: -She completed kitchen rounds once per week. -She checked for sanitation, first in, first out, food supply and any other kitchen concerns. -She conducted an audit of the kitchen on 06/26/19. -She was aware "the dish area needs repair, vents/fans have dust buildup, floors need to be repaired and tiles need to be replaced and repaired in the ceiling."	D 282		

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D 286	Continued From page 17	D 286		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Sufficient staff, space and equipment shall be provided for safe and sanitary food storage, preparation and service. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to have sufficient space for safe meal service. The findings are: Observation of the Special Care Unit (SCU) dining room on 07/10/19 between 12:00pm and 12:54pm revealed: -There were six tables set up to accommodate 20 residents. -The spaces between the table and chairs were narrow and limited. -Residents wheelchairs and walkers were sitting in the adjoining living room. -There was one walker and one wheelchair present in the dining room. -A resident in a wheelchair was moved away from her table prior to the lunch meal service to move other residents around in the dining room. -A resident was observed trying to exit the dining room; she had to pick up her walker several times and move it around chairs and wheelchairs. Observation of the SCU dining room on 07/11/19 between 8:15am and 9:15am revealed: -There were six tables set up to accommodate 20 residents.	D 286		

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-The spaces between the table and chairs were narrow and limited.
-A personal care aide (PCA) moved a resident away from the table and then slid the table to the resident in an attempt to make more room.
-A PCA was pushing an empty wheelchair out of the dining room; she was bumping into chairs with the wheelchair and commented: "This place is so tiny."

Observation of the living room area on 07/11/19 at 8:29am revealed:
-A female resident in her wheelchair waiting to be placed at her table.
-A PCA told the resident "we will get you in there in just a minute" that they were waiting on another resident to go into the dining room.
-Approximately 3 minutes later the PCA said "they are taking too long" and pushed the female resident up to her assigned table.

Observation of the SCU dining room on 07/11/19 at 9:03am revealed a resident had to be moved away from her table so a second resident could leave the dining room.

Interview with a resident on 07/11/19 at 9:15am revealed:
-The SCU dining room was crowded.
-She had to time it just right to be able to leave her table.
-She had to learn to be patient.
-It could be aggravating at times.

Confidential interviews with SCU staff on 07/11/19 revealed:
-The dining room was "tight."
-The dining room should have been built bigger.
-There had been times the staff would have to walk residents out of the dining room and then

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give them their walker because there was not enough room for the residents to walk out with the walker.
-They try to take residents in wheelchairs into the dining last, so they did not have to move other residents.
-When there was a lot of staff in the dining room to assist the residents, it made it "even more crowded."
-They have to move residents' tables around to make more space.

Interview with a resident on 07/11/19 at 9:35am revealed:
-The SCU dining room had "so many people."
-She did not take her walker into the dining room because it was crowded.
-She had to be careful walking without her walker.

Confidential interviews with family members on 07/11/19 revealed:
-There were several residents in wheelchairs that had to be maneuvered among chairs in the dining room.
-The staff always had to move other residents out of the way to get residents to their seats.
-The SCU dining room was always "chaotic".

Interview with the SCU Coordinator on 07/11/19 at 10:26am revealed:
-She had been working at the facility for about 3 weeks.
-The staff tried to seat the residents in the dining room from back to front to help alleviate having to move other residents around.
-The staff tried to transfer the residents in wheelchairs to regular chairs to help with spacing.
-She had seen residents weave in/out of chairs to get in and out of the dining room.
-The staff tried not to disrupt residents eating to

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D 286	Continued From page 20 move residents in and out of the dining room. -She had talked to the Executive Director about the spacing. -They were trying to think of a way to make the space more efficient. Interview with the Health and Wellness Director on 07/11/19 at 10:43am revealed: -She floated between the assisted living dining Room and the SCU dining room at least a couple of times per week. -She had noticed the "tightness" of the SCU dining room. -It would be nice to have a bigger space. -The residents in wheelchairs were transferred into dining room chairs at meals to help with spacing. Interview with the Executive Director on 07/13/19 at 10:48am revealed: -The residents were "packed" into the SCU dining room. -She noticed space was tight when she started to work at the facility, 12/31/18. -She had waited to hire the SCU Coordinator to implement any new plans because that person would be the one to carry out any changes. -She had met with representatives from corporate to get ideas on how to better utilize the space in the SCU dining room and living room. -They were looking at purchasing bistro type tables with smaller tops and bases to improve the spacing. -They had discussed utilizing the living room area during meals to have more space.	D 286		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights	D 338		

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D 338	Continued From page 21 An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure that all residents were treated with dignity and respect. The findings are: Based on observations, interviews and record reviews, the facility failed to treat 2 of 9 residents (#8, #9) with respect and dignity related to not providing assistance or prompting to a resident with vision impairments, who ate their food with their fingers (#8, #9); and rushing a resident to finish her lunch meal (#9). [Refer to Tag D911, G.S 131D-21(1) Declaration of Residents' Rights (Type B Violation)].	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D 344		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders and treatments for 2 of 7 sampled residents (#2 and #3) regarding orders for a medication used to lower cholesterol (#2) and an order for fingerstick blood sugars and an eye scrub (#3).

The findings are:

1. Review of Resident #2's current FL-2 dated 07/03/19 revealed:
-Diagnosis included type two diabetes, diabetic retinopathy, cervical radiculopathy, and amputation of left toe.
-There was a medication order for atorvastatin calcium (used to treat abnormal lipid levels) 80 mg once daily.

Review of Resident #2's hospital discharge notes dated 04/23/19 revealed an order for atorvastatin calcium 80 mg take one tablet every day for cholesterol.

Observation of Resident #2's medication on hand on 07/10/19 at 11:05 am revealed:
-There was a bottle of atorvastatin calcium 80 mg and the label read take one tablet once a day for cholesterol.
-Ninety tablets of the atorvastatin calcium 80 mg were dispensed on 2/21/19.

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Observation of Resident #2's medication on hand on 07/11/19 at 12:08 pm revealed the bottle of atorvastatin calcium 80 mg had broken half tablets inside the bottle.

Review of the electronic medication administration review (e-MAR) for May 2019 revealed:
-There was an entry for atorvastatin calcium 80 mg give one tablet in the evening for cholesterol give half tablet in evening.
-Atorvastatin calcium was scheduled to be administered at 6:00 pm.
-Atorvastatin was documented as administered every day.

Review of the e-MAR for June 2019 revealed:
-There was an entry for atorvastatin calcium 80 mg give one tablet in the evening for cholesterol give half tablet in evening.
-Atorvastatin calcium was scheduled to be administered at 6:00 pm.
-Atorvastatin was documented as administered every day.

Review of the e-MAR for July 2019 revealed:
-There was an entry for atorvastatin calcium 80 mg give one tablet in the evening for cholesterol give half tablet in evening.
-Atorvastatin calcium was scheduled to be administered at 6:00 pm.
-Atorvastatin was documented as administered every day.

Interview with a medication aide (MA) on 07/10/19 at 11:25 am revealed:
-All of Resident #2's medications were dispensed in bottles.
-She entered medication orders from physicians into the e-MAR; she did not recall the last time

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she entered Resident #2's medication orders.
-Resident #2 had returned from the hospital on 07/03/19, she did not know who entered the information from the new FL-2 into the e-MAR.
-She did not know what the correct dosage to administer for the atorvastatin was after reading the e-MAR; the physician should have been called or faxed for clarification of the dosage.
-If she had a question on a dosage she would wait for the physician to clarify the dosage before administering the medication.
-She did not work evenings, so she did not administer Resident #2 the atorvastatin.

Telephone interview with a second MA on 07/11/19 at 11:00 am revealed:
-She administered Resident #2 the atorvastatin in the evenings.
-She administered half a tablet of atorvastatin to Resident #2 because the label on the bottle said to give half a tablet and she followed the directions on the bottle.
-The e-MAR said to give a half a tablet of atorvastatin to Resident #2; half of a tablet was 40 mg.
-She updated the e-MAR when residents had new physician's orders, new FL-2s or medication changes, but she did not remember the last time she had updated Resident #2's e-MAR.

Telephone interview with the Pharmacist for the contracted pharmacy on 07/11/19 at 9:54 am revealed:
-She did the quarterly pharmacy reviews for the facility.
-She compared the physician orders to the e-MAR to ensure the e-MAR was correct.
-She would let the Health and Wellness Director (HWD) know of any discrepancies between the physician's orders and the e-MAR and would

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make recommendations to the HWD.
-The facility staff entered physician's orders into the e-MAR; she was not contacted about questions on the dosage for Resident #2's atorvastatin.
-The dosage for Resident #2's atorvastatin on the e-MAR was confusing; she understood the dosage on the e-MAR to be half of an 80 mg tablet of atorvastatin.
-The dosage on the e-MAR was not clear and facility staff should have checked the FL-2 or the physician's order.
-If Resident #2 was incorrectly administered half of the dosage of atorvastatin over a period of three months the adverse effects would be his lipids would not be as controlled as they should have been.

Telephone interview with Resident #2's Nurse Practitioner (NP) on 07/11/19 at 12:40 pm revealed:
-Resident #2 was ordered atorvastatin 80 mg one tablet once daily; Resident #2 was ordered atorvastatin to help control his lipid levels.
-She did not want Resident #2 to take a half a tablet.
-She expected the MA or the HWD to contact her if there was a discrepancy in orders and she expected Resident #2's medication to be administered as ordered.
-Facility staff had not contacted her for clarification of any orders for Resident #2.

Interview with the HWD on 07/11/19 at 10:30 am revealed:
-MAs were supposed to check the e-MAR and the label on the medication before administering medication to a resident.
-MAs entered new orders and order changes into the eMAR; when there was a question about

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orders the MAs were responsible for faxing clarification of orders to physicians.
-She thought the atorvastatin dosage on the e-MAR was for half of a tablet, but she did not know if the dosage was for 40 mg or 80 mg.
-Staff had not informed her of any questions or concerns about Resident #2's atorvastatin dosage; staff should have requested clarification for the atorvastatin dosage.

Interview with the Health and Wellness Coordinator (HWC) on 07/11/19 at 8:15 am revealed:
-When a resident had a new FL-2 or physician's orders the new orders were faxed to the pharmacy that same day and a copy was placed into the resident's chart.
-The new FL-2 or orders were compared to the previous FL-2 and orders, if there was a question or discrepancy between the old the new orders a clarification would be sent to the physician via fax.
-The MAs were responsible for entering new orders into the e-MAR, for comparing orders and for requesting clarification for orders from the physician; the MAs handled the entire process.
-She had not had a chance to conduct e-MAR audits.

Interview with the Executive Director (ED) on 07/11/19 at 12:50 pm revealed:
-MAs and nurses (HWD and HWC) entered new orders into the eMAR.
-New orders, FL-2s and discharge summaries were supposed to be compared to the previous orders.
-When MAs saw a discrepancy in an order in medication they were to notify the HWD or HWC and one them would get clarification from the physician.
-Monthly audits of the e-MAR were conducted by

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the HWD.
-She thought the order on the e-MAR was not clear; she did not know if the dosage was for one whole tablet or a half tablet and staff should have requested a clarification order for Resident #2's atorvastatin.

2. a. Review of Resident #3's current FL-2 dated 06/18/19 revealed:
-Diagnoses included chest pain, chronic low back pain, spondylosis, chronic joint pain, dementia, and degenerative disc disease.
-There was no order for fingerstick blood sugars (FSBS).

Review of Resident #3's previous FL-2 dated 06/07/19 revealed there was no order for FSBS.

Review of a hospital discharge summary for Resident #3 dated 06/19/19 revealed:
-Resident #3's admitting diagnosis was chest pain.
-She was admitted to the hospital on 06/16/19 and discharged on 06/19/19.
-There was no order for FSBS.

Review of Resident #3's electronic medication administration record (e-MAR) for June 2019 revealed:
-There was a computer generated entry for FSBS before breakfast one time a day and call "MD" if FSBS greater than 450 or less than 60; there was a start date of 04/09/19.
-Resident #3's FSBS ranged from 176-291 in June 2019.

Review of Resident #3's e-MAR for July 2019 revealed:
-There was a computer generated entry for FSBS before breakfast one time a day and call "MD" if

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FSBS greater than 450 or less than 60.
-Resident #3's FSBS ranged from 234-325 from 07/01/19-07/09/19.

Telephone interview with a representative from the contracted pharmacy on 07/11/19 at 11:53am revealed the last order on file was dated 04/08/19 for FSBS daily.

Interview with Resident #3 on 07/11/19 at 2:00pm revealed:
-Staff checked her FSBS usually every day.
-She had a diagnosis of diabetes and took two pills for diabetes.

Interview with the Health and Wellness Director on 07/10/19 at 9:30am revealed:
-The resident had back surgery in May 2019 and went to a rehabilitation facility.
-She went back to the hospital for a few days in June 2019.
-Her current orders would be on the hospital generated FL-2 and discharge summary.
-The primary care provider (PCP) received a copy of her current e-MAR on every visit; the PCP was at the facility twice a week.
-The Health and Wellness knew the PCP had recently changed her medication for constipation, but she was not sure about any changes in FSBS.

Interview with the MA/Supervisor on 07/11/19 at 11:20am revealed:
-Resident #3 came back to the facility from a rehabilitation facility on 06/11/19, and then went back to the hospital a few days later.
-The MAs faxed new orders to the pharmacy, and entered new orders into the e-MAR system also.
-The nurses (Health and Wellness Director and Health and Wellness Coordinator) checked

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behind the MAs for accuracy when transcribing new orders or discontinuing old orders
-Resident #3 was getting FSBS checks daily.
-The last order for FSBS was 04/08/19, which was prior to the new FL-2 and should have been clarified by her or the nurses.

Telephone interview with Resident #3's PCP on 07/11/19 at 12:15pm revealed:
-He could not recall what was ordered for Resident #3 regarding FSBS, but she did not need to have FSBS checked.
-She was not taking insulin and therefore, did not need them.

Interview with the Executive Director on 07/11/19 at 12:54pm revealed:
-Staff were supposed to follow the FL-2 after they returned from rehab or the hospital.
-The MAs should send a fax to the PCP for any clarification of orders and document this in the nurse's notes.
-The MAs and/or nurses should read the hospital discharge summary and make any changes in the e-MAR.
-If there was any discrepancy, the MAs should reach out to the nurses, and the nurses should reach out to the PCP or other provider; the MAs could also call the PCP.
-She had recently implemented a readmit note should be documented in the nurse's notes for residents who came back from a hospital or rehab stay.
-She had also implemented monthly audits to be completed by the Health and Wellness Director.
-The Regional Nurse did random audits as well, and pharmacy reviews; the last audit was done recently, maybe at the end of May 2019.
-The internal audit was last completed by the Health and Wellness Director about 1 ½-2 weeks

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ago, which was the first audit completed.
-She had not been given a copy of the results from the audit.

b. Review of Resident #3's previous FL-2 dated 06/07/19 revealed there was an order for OcuSoft Lid Scrub pad (an eyelid cleanser) to both eyes daily for dry eyes.

Review of Resident #3's current FL-2 dated 06/18/19 revealed there was no order for OcuSoft Lid Scrub pad daily.

Review of Resident #3's electronic medication administration record (e-MAR) for June 2019 revealed:
-There was a computer generated entry for OcuSoft Lid Scrub Pad, apply to both eye lids topically one time a day for dry eyes; there was a discontinue date of 06/11/19 next to the entry.
-There was documentation the OcuSoft Lid Scrub Pad was administered from 06/01/19-06/11/19 at 8:00am.
-There was a second entry for OcuSoft Lid Scrub Pad, apply to both eye lids topically one time a day for dry eyes, with a start date of 06/12/19.
-There was documentation the OcuSoft Lid Scrub Pad was administered from 06/12/19-06/16/19; and from 06/20/19-06/30/19 at 9:00am.

Review of Resident #3's e-MAR for July 2019 revealed:
-There was an entry for OcuSoft Lid Scrub Pad, apply to both eye lids topically one time a day for dry eyes, scheduled at 9:00am.
-There was documentation the OcuSoft Lid Scrub Pad was administered daily from 07/01/19-07/09/19.

Observation of Resident #3's medication on hand

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on 07/10/19 at 5:00pm revealed there were eleven pads remaining out of 30 dispensed on 03/22/19.

Telephone interview with a representative from the contracted pharmacy on 07/11/19 at 11:53am revealed:
-There was an order on file dated 06/07/19.
-Thirty pads were dispensed prior to the resident's rehab stay on 03/22/19, and none had been requested since.
-The staff would have to request a refill when the resident was out of the scrub pads.

Interview with Resident #3 on 07/09/19 at 10:05am revealed the staff sometimes gave her the scrub pads for her eyes, and sometimes they did not.

Interview with the Health and Wellness Director on 07/10/19 at 9:30am revealed:
-Her current orders would be on the hospital generated FL-2 and discharge summary 06/18/19.
-The primary care provider (PCP) received a copy of her current e-MAR on every visit; the PCP was at the facility twice a week.

Second interview with the Health and Wellness Director on 07/10/19 at 11:10am revealed:
-She or the Health and Wellness Coordinator transcribed new orders on the e-MAR by entering into the computer system.
-They could also discontinue old orders or orders the provider discontinued or changed.
-The medication aides (MA) could also transcribe new orders.

Interview with the MA/Supervisor on 07/11/19 at 11:20am revealed:

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-The MAs faxed new orders to the pharmacy, and entered new orders into the e-MAR system also.
-The nurses (Health and Wellness Director and Health and Wellness Coordinator) checked behind the MAs for accuracy when transcribing new orders or discontinuing old orders.
-The scrub pads were not on the hospital discharge summary of orders, and should have been clarified by the MA or herself.

Telephone interview with Resident #3's PCP on 07/11/19 at 12:15pm revealed:
-He could not recall reviewing Resident #3's hospital discharge summary from June 2019.
-He did not recall staff requesting an order for the scrub pads, but it was fine for the resident to continue to use them for complaints of dry eyes.

Interview with the Executive Director on 07/11/19 at 12:54pm revealed:
-Staff were supposed to follow the FL-2.
-The MAs should send a fax to the PCP for any clarification orders and document this in the nurse's notes.
-The MAs and/or nurses should read the hospital discharge summary and make any changes in the e-MAR.
-If there was any discrepancy, the MAs should reach out to the nurses, and the nurses should reach out to the PCP or other provider; the MAs could also call the PCP.
-She had also implemented monthly audits to be completed by the Health and Wellness Director.
-The Regional Nurse did random audits as well, and pharmacy reviews; the last audit was done recently, maybe at the end of May 2019.
-The internal audit was last completed by the Health and Wellness Director about 1 ½-2 weeks ago, which was the first audit completed.
-She had not been given a copy of the results

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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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 7 sampled residents (#2, #3 and #6) related to medication used to treat mouth sores and a medication used to relieve pain (#6); a medication used to lower cholesterol (#2); and an anti-flammatory medication and a pain medication (#3). The findings are: 1. Review of Resident #6's most recent FL-2	D 358		

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dated 06/18/18 revealed diagnoses included Alzheimer's, major depressive disorder, glaucoma, age-related osteoporosis, and gastroesophageal reflux disease.

a. Review of Resident #6's physician's order dated 01/14/19 revealed an order for Aspercreme Lidocaine Patch 4%, apply one patch to lower back daily. (Aspercreme Lidocaine Patch 4% is used to temporarily relieve pain.).

Review of Resident #6's May 2019 through July 2019 electronic-Medication Administration Records (e-MAR) revealed:
-There was a computer-generated entry for Aspercreme Lidocaine Patch apply to the middle of back topically one time a day for pain scheduled at 8:00am.
-There was documentation Aspercreme Lidocaine Patch was applied at 8:00am daily from 05/01/19 through 07/10/19.
-There was no documentation Resident #6 was not administered Aspercreme Lidocaine Patch.

Observation of Resident #6's medications on hand on 07/10/19 at 10:00am revealed there was a plastic bag of single foiled packages of Aspercreme Lidocaine patches with a dispense date of 05/18/19 for 30 patches; there were 9 and ½ patches remaining in the plastic bag.

Telephone interview with a Pharmacist at the contracted pharmacy on 07/10/19 at 10:52AM revealed:
-Resident #6's Aspercreme Lidocaine Patch was dispensed on 04/09/19 for 30 patches and 05/08/19 for 30 patches.
-The Aspercreme Lidocaine Patch was considered a bulk medication and was only refilled when requested by the facility staff.

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-If the Aspercreme Lidocaine Patch was applied as ordered there would not be any patches available to be applied based on date and quantity dispensed.

Interview with a medication aide (MA) on 07/10/19 at 11:26am revealed:
-Resident #6 had an order for a pain patch to be applied daily.
-She applied a whole patch daily when she was working; she did not know why there was a half of a patch in the plastic bag .
-She did not know why there were patches remaining from a dispensed date of 05/08/19.
-Pain patches were a bulk medication and were ordered before the last patch was applied; it had not been reordered because there were pain patches remaining for Resident #6.

Interview with a second MA on 07/10/19 at 4:38pm revealed:
-She applied a pain patch for Resident #6 on 07/10/19.
-She always applied a pain patch for Resident #6 on the days she worked.
-Resident #6 never refused having a pain patch applied.
-She always applied a whole patch.

Interview with the Health and Wellness Director (HWD) on 07/10/19 at 4:38pm revealed:
-Medication cart audits were done randomly; the e-MAR and the medications on hand were compared.
-She was not aware Resident #6's pain patches were not being applied as ordered.
-She was concerned Resident #6's pain patches were not being applied as ordered.
-Based on the dispensing records for the pain patch for Resident #6 the pain patches should

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have been used and reordered by now.
-Resident #6 would not have pain relief if her pain patch was not applied daily as ordered.

Interview with Resident #6's Primary Care Provider (PCP) on 07/11/19 at 9:57am revealed:
-If Resident #6's pain patch was not being applied as ordered she would not get the pain relief she needed.
-If the pain patch was ordered to be applied daily he expected it to be applied daily.
-He was concerned the physician's orders were not being followed for the pain patch.

Interview with the Pharmacy Consultant on 07/11/19 at 10:05am revealed:
-She completed a quarterly review on Resident #6 on 06/26/19.
-She did not look at medications on hand for the pain patch for Resident #6.

Interview with the Executive Director (ED) on 07/11/19 at 10:48am revealed:
-If Resident #6 had her pain patch applied as ordered the medication would have needed to be reordered.
-She was concerned Resident #6 did not have her pain patch applied as ordered; "we could have caused her to have pain by not applying the pain patch."
-The MAs were supposed to be double checking orders; she was concerned the MAs were on "auto-pilot" when administering and documenting medications.

Based on observations, interview and record review, Resident #6 was not interviewable.

Based on observations, interviews, and record reviews, the Aspercreme Lidocaine Patch could

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not have been applied daily as documented on Resident #6's May 2019-July 2019 e-MARs according to the amount of Aspercreme Lidocaine Patch dispensed from the pharmacy compared to the amount required for daily application.

b. Review of Resident #6's physician's order dated 06/21/19 revealed an order for Magic Mouthwash swish and swallow 5ml by mouth QID (four times daily) for 7-days. (Magic Mouthwash is used to temporarily relieve mouth pain.).

Review of Resident #6's June 2019 through July 2019 electronic Medication Administration Records (e-MAR) revealed:
-There was a computer-generated entry for Magic Mouthwash swish and swallow 5ml every other day for sore mouth with an administration time of 8:00am.
-There was documentation Magic Mouthwash was administered at 8:00am on 06/25/19, 06/27/19, 06/29/19, 07/01/19, 07/03/19, 07/05/19, 07/07/19 and 07/09/19.
-There was no stop dated documented.
-Magic Mouthwash was not administered four times a day for seven days as ordered.

Observation of medications on hand for Resident #6 on 07/10/19 at 10:00am revealed:
-There was a bottle of Magic Mouthwash in a clear plastic bag.
-The bottle was labeled swish and swallow one teaspoon (5ml) by mouth four times a day for seven days.
-The Magic Mouthwash was dispensed on 06/21/19.

Interview with a medication aide (MA) on 07/10/19 at 11:26am revealed:
-She did not administer Resident #6's Magic

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Mouthwash today; it was not scheduled to be administered today, 07/10/19.
-MAs entered orders into the e-MAR system; whoever was working when the order came in was responsible for entering the order into the e-MAR.
-She put the order for the Magic Mouthwash into the e-MAR.
-She thought the direction for QID meant every other day; she got QID and QOD confused.
-She thought she had put a stop date for the Magic Mouthwash; she must have missed it.
-Resident #6 had never complained of mouth pain; she did not know why the Magic Mouthwash was being used.

Interview with a second MA on 07/10/19 at 4:38pm revealed:
-The MAs were responsible for entering orders that came into the facility on that shift into the residents eMAR.
-She administered Resident #6's Magic Mouthwash on 07/09/19.
-She was supposed to look at the bottle and compare it to the eMAR; she did not recall if she had compared Resident #6's bottle of Magic Mouthwash to Resident #6'se MAR.

Interview with the Health and Wellness Director (HWD) on 07/10/19 at 4:51pm revealed:
-Medication cart audits were done randomly at least every other month.
-The MAs or the HWD entered the orders into the e-MARs.
-They had a tracking form to track the medication, make sure the order was faxed to the pharmacy, the order was put into the e-MAR and the medication arrived to be administered.
-The MA put the order in the e-MAR wrong and the e-MAR did not get a second look; a second

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staff should have compared the order to the e-MAR and medication on hand.
-Their policy was all orders had a second look to verify it was entered correctly into the eMAR.
-She was concerned the MAs did not read the label; they were supposed to read the label three times at every medication pass.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/11/19 at 1:04pm revealed:
-Resident #6's Magic Mouthwash was ordered to be used four times a day for seven days.
-The facility staff entered all medication orders into the e-MAR system.
-If the Magic Mouthwash was used once a day every other day Resident #6's mouth ulcers would take longer to improve.
-If Resident #6's Magic Mouthwash was used as ordered her mouth ulcers would have cleared up faster.

Telephone interview with the Pharmacy Consultant on 07/11/19 at 10:05am revealed:
-If something needed attention, she would tell the facility's nurse (HWD); she also emailed her report to the HWD.
-The HWD printed out the report and put it in a notebook at the facility; a copy was given to the PCP as well.
-On 06/26/19 she completed a review of Resident #6's e-MAR; she looked at the medication on hand for Magic Mouthwash because of the discrepancy in the order.
-She sent a note to the HWD with the discrepancy, the order said to administer Magic Mouthwash four times a day for seven days and the order in the e-MAR had every other day with no end date; she asked for clarification.

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D 358	Continued From page 40 Interview with the Executive Director on 07/11/19 at 10:48am revealed: -The MAs received orders and transcribed the order into the MAR system. -If the order was entered correctly, it would have been blocked out after 7-days. -The MAs were supposed to be double-checking orders; she was concerned the MAs were on "auto-pilot" when administering and documenting medications. -She was concerned Resident #6 was not administered her Magic Mouthwash as ordered. Based on observations, interview and record review, Resident #6 was not interviewable. Refer to interview with the Executive Director on 07/11/19 at 12:54pm. 2. Review of Resident #2's current FL-2 dated 07/03/19 revealed: -Diagnoses included type two diabetes, diabetic retinopathy, cervical radiculopathy, and amputation of left toe. -There was a medication order for atorvastatin calcium (used to treat abnormal lipid levels) 80 mg once daily. Review of Resident #2's hospital discharge notes dated 04/23/19 revealed an order for atorvastatin calcium 80 mg take one tablet every day for cholesterol. Observation of Resident #2's medication on hand on 07/10/19 at 11:05 am revealed: -There was a bottle of atorvastatin calcium 80 mg and the label read take one tablet once a day for cholesterol. -Ninety tablets of the atorvastatin calcium 80 mg were dispensed on 02/21/19.	D 358		

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D 358	Continued From page 41 Observation of Resident #2's medication on hand on 07/11/19 at 12:08 pm revealed the bottle of atorvastatin calcium 80 mg had broken half tablets inside the bottle. Review of the electronic medication administration record (e-MAR) for May 2019 revealed: -There was an entry for atorvastatin calcium 80 mg give one tablet in the evening for cholesterol give half tablet in evening. -Atorvastatin calcium was scheduled to be administered at 6:00 pm. -Atorvastatin was documented as administered every day. Review of the e-MAR for June 2019 revealed: -There was an entry for atorvastatin calcium 80 mg give one tablet in the evening for cholesterol give half tablet in evening. -Atorvastatin calcium was scheduled to be administered at 6:00 pm. -Atorvastatin was documented as administered every day. Review of the e-MAR for July 2019 revealed: -There was an entry for atorvastatin calcium 80 mg give one tablet in the evening for cholesterol give half tablet in evening. -Atorvastatin calcium was scheduled to be administered at 6:00 pm. -Atorvastatin was documented as administered every day. Interview with a medication aide (MA) on 07/10/19 at 11:25 am revealed: -All of Resident #2's medications were dispensed in bottles. -She entered medication orders from physicians	D 358		

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into the e-MAR; she did not recall the last time she entered Resident #2's medication orders.
-She did not know what the correct dosage to administer for the atorvastatin was after reading the e-MAR; she would have used the dosage on the bottle and called the physician for clarification.
-She did not work evenings, so she did not administer Resident #2 the atorvastatin.

Telephone interview with a second MA on 07/11/19 at 11:00 am revealed:
-She administered Resident #2 the atorvastatin in the evenings.
-The atorvastatin came from the pharmacy in a bottle and were whole tablets; she cut the atorvastatin tablets in half and she placed the unused half of the atorvastatin tablet back into the bottle.
-She administered half a tablet of atorvastatin to Resident #2 because the label on the bottle said to "cut the tablet in half "and she followed the directions on the bottle.
-The e-MAR said to give a half a tablet of atorvastatin to Resident #2; half of a tablet was 40 mg.
-She updated the e-MAR when residents had new physician's orders, new FL-2s or medication changes, but she did not remember the last time she had updated Resident #2's e-MAR.

Telephone interview with the pharmacist consult from the contracted pharmacy on 07/11/19 at 9:54 am revealed:
-She did the quarterly pharmacy reviews for the facility.
-She compared the physician orders to the e-MAR to ensure the e-MAR was correct.
-She would let the Health and Wellness Director (HWD) know of any discrepancies between the physician's orders and the e-MAR and would

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make recommendations to the HWD.
-The dosage for Resident #2's atorvastatin on the e-MAR was confusing; she understood the dosage on the e-MAR to be half of an 80 mg tablet of atorvastatin.
-The dosage on the e-MAR was not clear and facility staff should have checked the FL-2 or the physician's order.
-If Resident #2 was incorrectly administered half of the dosage of atorvastatin over a period of three months the adverse effects would be his lipids would not be as controlled as they should have been.
-She did not check the medication on the medication cart unless she had a concern.
-She had not checked Resident #2's medication on hand on the medication cart for any of the pharmacy reviews she conducted.

Telephone interview with Resident #2's nurse practitioner (NP) on 07/11/19 at 12:40 pm revealed:
-Resident #2 was ordered atorvastatin 80 mg one tablet once daily; Resident #2 was ordered atorvastatin to help control his lipid levels.
-Facility staff had not contacted her for clarification of any orders for Resident #2.
-She did not want Resident #2 to take a half a tablet and she was not aware Resident #2 had been administered a half a tablet.
-The outcome from only taking half of the ordered dosage could be lipid levels would not be lowered much as they would have been with full dosage.

Interview with the HWD on 07/11/19 at 10:30 am revealed:
-MAs were supposed to check the e-MAR and the label on the medication before administering medication to a resident.
-MAs entered orders into the e-MAR; MAs were

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responsible for faxing clarification of orders to physicians.
-She thought the atorvastatin dosage on the e-MAR was for half of a tablet, but she did not know if the dosage was for 40 mg or 80 mg.
-Staff had not informed her of any questions or concerns about Resident #2's atorvastatin dosage; staff should have requested clarification for the atorvastatin dosage.

Interview with the Executive Director (ED) on 07/11/19 at 12:50 pm revealed:
-MAs entered new orders into the e-MAR.
-MAs were supposed to compare the dosage on the eMAR to the label on the medication before administering any medication.
-When MAs saw a discrepancy in an order in medication they were to notify the HWD and the HWD would get clarification from the physician.
-The order on the e-MAR for Resident #2's atorvastatin was difficult to understand; the MA should have asked for clarification or referred back to the original physician's order.

Refer to interview with the Executive Director on 07/11/19 at 12:54pm.

3. Review of Resident #3's current FL-2 dated 06/18/19 revealed diagnoses included chest pain, chronic low back pain, spondylosis, chronic joint pain, dementia, and degenerative disc disease.

a. Review of Resident #3's previous FL-2 dated 06/07/19 revealed an order for oxycodone 5mg every 6 hours as needed (oxycodone is a narcotic used to treat moderate to severe pain).

Review of a subsequent physician order for Resident #3 revealed an order dated 06/10/19 for oxycodone 5mg every 6 hours as needed.

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D 358	Continued From page 45 Review of a hospital discharge summary for Resident #3 dated 06/19/19 revealed: -Resident #3's admitting diagnosis was chest pain. -She was admitted to the hospital on 06/16/19 and discharged on 06/19/19. -There was an order for oxycodone 5mg ½ tablet twice daily as needed. Review of a subsequent physician order for Resident #3 dated 07/02/19 revealed an order for oxycodone 5mg ½ tablet twice daily. Review of Resident #3's electronic medication administration record (e-MAR) for June 2019 revealed: -There was a computer generated entry for oxycodone 5mg tablet, give ½ tablet two times a day for pain, scheduled for 8:00am and 8:00pm. -Oxycodone 5mg ½ tablet was documented as administered twice daily from 06/01/19-06/10/19, and at 8:00am on 06/11/19. -A discontinue date of 06/11/19 was entered by the entry. -There was a second computer generated entry for oxycodone 5mg, give one tablet by mouth every 6 hours as needed for pain. -Oxycodone 5mg, one tablet, was documented as administered once on 06/13/19 and 06/14/19; twice on 06/15/19; and once on 06/16/19 and 06/20/19. -There was a discontinue date of 06/20/19 by the entry. -There was a third computer generated entry for oxycodone 5mg, give 2.5mg every 12 hours as needed for pain, with a discontinue date of 06/11/19 by the entry. -There was no documentation of administration by this entry.	D 358		

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-There was a fourth computer generated entry for oxycodone 5mg, give 2.5mg every 12 hours as needed for pain.
-There was documentation oxycodone 2.5 mg was administered once on 06/22/19, 06/24/19 and 06/25/19.

Review of Resident #3's e-MAR for July 2019 revealed:
-There was a computer generated entry for oxycodone 5mg, give 2.5mg every 12 hours as needed for pain.
-There was documentation oxycodone 2.5 mg every 12 hours as needed for pain was administered once on 07/06/19.
-There was no entry for oxycodone 5mg, ½ tablet, twice daily.

Observation of Resident #3's medication on hand on 07/10/19 at 5:00pm revealed:
-There were 14 half tablets available for administration dispensed on 07/02/19.
-The label read to administer oxycodone 5mg, 1/2 tablet (2.5mg) twice daily.

Telephone interview with a representative from the contracted pharmacy on 07/11/19 at 11:53am revealed:
-The last order received was for oxycodone 5mg, give 2.5mg, twice daily on 07/02/19.
-Fifteen ½ tablets (2.5mg) were dispensed to the facility on 07/02/19.

Interview with Resident #3 on 07/09/19 at 10:05am revealed:
-She had pain frequently in her leg that she took medication for.
-It was hard to do any activities because of the pain and she did not go downstairs for meals.
-Staff brought her meals to her in her room and

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D 358	Continued From page 47 she ate in her recliner. Interview with the Health and Wellness Director on 07/10/19 at 9:30am revealed: -The resident had back surgery in May 2019 and went to a rehabilitation facility. -She went back to the hospital for a few days in June 2019. -Her current orders would be on the hospital generated FL-2 and discharge summary. -She knew the PCP had recently changed her medication for constipation, but she was not sure about any changes in pain medication. Second interview with the Health and Wellness Director on 07/10/19 at 11:10am revealed: -She or the Health and Wellness Coordinator transcribed new orders on the e-MAR by entering into the computer system. -The medication aides (MA) could also transcribe new orders. Interview with the MA/Supervisor on 07/11/19 at 11:20am revealed: -The MAs faxed new orders to the pharmacy, and entered new orders into the e-MAR system also. -The nurses (Health and Wellness Director and Health and Wellness Coordinator) checked behind the MAs for accuracy when transcribing new orders. -Resident #3's oxycodone was currently as needed, not twice daily routinely. -The order dated 06/19/19 from the hospital was sent to the PCP, so he saw all the orders from the hospital. -The order dated 07/02/19 written by the PCP was missed; it was an oversight. Telephone interview with Resident #3's PCP on 07/11/19 at 12:15pm revealed:	D 358		

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-He had ordered the oxycodone twice daily routinely due to her complaints of knee and leg pain.
-He would prefer the oxycodone be ordered as needed.

b. Review of a hospital discharge summary for Resident #3 dated 06/19/19 revealed:
-Resident #3's admitting diagnosis was chest pain.
-There was an order for meloxicam 15mg, ½ tablet, daily (meloxicam is an anti-inflammatory used to treat pain).

Review of Resident #3's electronic medication administration record (e-MAR) for June 2019 revealed:
-There was a computer generated entry for meloxicam 15mg, one tablet daily for nerve pain, scheduled for 1:00am.
-There was a discontinue date of 06/11/19 next to the entry.
-There was no documentation the meloxicam was administered in June 2019.
-There were no other entries for meloxicam on the June 2019 e-MAR.

Review of Resident #3's e-MAR for July 2019 revealed there was no entry for meloxicam 15mg, ½ tablet, daily.

Observation of Resident #3's medication on hand on 07/10/19 at 5:00pm revealed there was no meloxicam available for administration.

Telephone interview with a representative from the contracted pharmacy on 07/11/19 at 11:53am revealed:
-There was an order on file for meloxicam dated 06/10/19.

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D 358	Continued From page 49 -Twenty eight tablets were dispensed to the facility on 06/14/19, but all 28 tablets were sent back to the pharmacy by facility staff. -The resident received a credit for the meloxicam that was dispensed. -There was a second order dated 06/19/19, but none were dispensed since the previous supply was sent back. Interview with Resident #3 on 07/09/19 at 10:05am revealed: -She had pain frequently in her leg. -It was hard to do any activities because of the pain and she did not go downstairs for meals. -Staff brought her meals to her in her room and she ate in her recliner. Interview with the Health and Wellness Director on 07/10/19 at 9:30am revealed: -Her current orders would be on the hospital generated FL-2 and discharge summary. -The primary care provider (PCP) received a copy of her current e-MAR on every visit; the PCP was at the facility twice a week. -The Health and Wellness Director knew the PCP had recently changed her medication for constipation, but she was not sure about any changes in pain medication. Second interview with the Health and Wellness Director on 07/10/19 at 11:10am revealed: -She or the Health and Wellness Coordinator transcribed new orders on the e-MAR by entering into the computer system. -The medication aides (MA) could also transcribe new orders. Interview with the MA/Supervisor on 07/11/19 at 11:20am revealed: -The MAs faxed new orders to the pharmacy, and	D 358		

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entered new orders into the e-MAR system also.
-The nurses (Health and Wellness Director and Health and Wellness Coordinator) checked behind the MAs for accuracy when transcribing new orders.
-The meloxicam was not on Resident #3's medication list from rehabilitation facility.
-The order dated 06/19/19 from the hospital was sent to the PCP, so he saw all the orders from the hospital.
-The PCP must not have wanted her taking meloxicam.
-There was no discontinue order for meloxicam.

Telephone interview with Resident #3's PCP on 07/11/19 at 12:15pm revealed:
-He could not recall reviewing Resident #3's hospital discharge summary from June 2019.
-The hospital physician should not have re-ordered the meloxicam for Resident #3.
-He had previously discontinued it because Resident #3's pain was under control with other medication he had prescribed.

Interview with the Executive Director on 07/11/19 at 12:54pm revealed:
-Staff were supposed to follow the FL-2 after they returned from rehab or the hospital.
-The MAs should send a fax to the PCP for any clarification orders and document this in the nurse's notes.
-The MAs and/or nurses should read the hospital discharge summary and make any changes in the e-MAR.
-If there was any discrepancy, the MAs should reach out to the nurses, and the nurses should reach out to the PCP or other provider; the MAs could also call the PCP.
-She had recently implemented a readmit note should be documented in the nurse's notes for

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D 358	Continued From page 51 residents who came back from a hospital or rehab stay. -She had also implemented monthly audits to be completed by the Health and Wellness Director. -The Regional Nurse did random audits as well, and pharmacy reviews; the last audit was done recently, maybe at the end of May 2019. -The internal audit was last completed by the Health and Wellness Director about 1 ½-2 weeks ago, which was the first audit completed. -She had not been given a copy of the results from the audit. The facility failed to administer medications as order to three residents, including a topical pain medication and a medication for relief of mouth pain to Resident #6; a cholesterol medication to Resident #2; and a narcotic pain medication and an anti-inflammatory medication to Resident #3, who had a history of chronic back pain, chest pain, spondylosis and chronic joint pain. This failure was detimental to the health, safety and welfare of the residents; and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/10/19 for this violation. THE CORRECTION DATE SHALL NOT EXCEED AUGUST 25, 2019 FOR THE TYPE B VIOLATION.	D 358		
D 382	10a NCAC 13F .1006 (f) Medication Storage 10a NCAC 13F .1006 Medication Storage (f) Medications requiring refrigeration shall be stored at 36 degrees F to 46 degrees F (2	D 382		

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D 382	Continued From page 52 degrees C to 8 degrees C). This Rule is not met as evidenced by: Based on observation and interview the facility failed to assure medications requiring refrigeration were stored between 36 degrees Fahrenheit (F) to 46 degrees F. The findings are: Review of Resident #6's most recent FL-2 dated 06/18/18 revealed diagnoses included Alzheimer's, major depressive disorder, glaucoma, age-related osteoporosis, and gastroesophageal reflux disease. Review of Resident #6's physician's order dated 06/21/19 revealed an order for Magic Mouthwash swish and swallow 5ml by mouth QID (four times daily) for 7-days. (Magic Mouthwash is used to temporarily relieve mouth pain.). Observation of medications on hand for Resident #6 on 07/10/19 at 10:00am revealed: -There was a bottle of Magic Mouthwash in a clear plastic bag. -The clear plastic bag was labeled "refrigerate." -The bottle had a sticker, "refrigerate shake well." -The bottle was in the medication cart. -The bottle was not refrigerated. Interview with a medication aide (MA) on 07/10/19 at 11:26am revealed: -She had not noticed the Magic Mouthwash needed to be refrigerated. -She would have put the medication in the refrigerator had she noticed the label.	D 382		

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D 382	Continued From page 53 Interview with a second MA on 07/10/19 at 4:38pm revealed: -MAs were supposed to look at the medication label at every med pass. -She had not noticed the Magic Mouthwash was labeled to be refrigerated. Telephone interview with a representative from the facility's contracted pharmacy on 07/11/19 at 1:04pm revealed: -Their pharmacy's guidelines for Magic Mouthwash were to refrigerate the medication and discard after 14-days. -If the medication was not refrigerated and was used after 14-days it may not be as effective. Interview with the Health and Wellness Director (HWD) on 07/10/19 at 4:51pm revealed: -If a medication was labeled to be refrigerated, it should have been refrigerated. -She did not know why the Magic Mouthwash was not refrigerated if it was labeled to be refrigerated. -Medication cart audits were done randomly at least every other month. -Medication arrived from the pharmacy in a tote; if it was supposed to be refrigerated, it would have been sent with ice packs. -If the medication was on an ice pack, it would also direct the staff to refrigerate. -The staff should have seen the directions to refrigerate. -She was concerned the staff did not read the label; they were supposed to read the label three times at every medication pass. Interview with the Executive Director (ED) on 07/11/19 at 10:48am revealed: -She was concerned the medication aides were not paying attention. -If the medication was labeled to be refrigerated,	D 382		

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D 382	Continued From page 54 it should have been refrigerated. Based on observations, interview and record review, Resident #6 was not interviewable.	D 382		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the county Department of Social Services (DSS) was notified of accidents and incidents which resulted in injury to 2 of 7 sampled residents (#2 and #1) who required a referral for emergency medical evaluation other than first aid. The findings are: 1. Review of Resident #2's current FL2 dated 07/03/19 revealed diagnosis included type two diabetes, diabetic retinopathy, cervical radiculopathy, and amputation of left toe.	D 451		

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D 451	Continued From page 55 Review of a Post-Fall evaluation form for Resident #2 dated 04/23/19 revealed: -Resident #2 complained to the medication aide of pain in both of his thumbs; he reported his pain was 10 out of 10 on the pain scale with 10 being the highest level of pain. -Resident #2 fell in his room and there were no witnesses to the fall. -Resident #2 reported he fell putting on his pants on while standing. -There was no indication on the Post Fall evaluation form that emergency services were sought for Resident #2. -There was no indication an incident form was submitted to DSS. Review of a discharge summary from a local hospital dated 04/23/19 revealed: -Resident #2 was seen in the emergency department for a fall and bilateral hand pain related to the fall. -He received splints on both hands and was referred to an orthopedic physician. Review of a visit summary to a local orthopedic surgeon dated 04/29/19 revealed Resident #2 was seen for bilateral hand pain related to a fall; his diagnosis was contusion of the left thumb without damage to the nail. Interview with a medication aide (MA) on 07/10/19 at 4:30pm revealed: -Sometime in April 2019 between 7:00 pm and 7:30 pm, Resident #2 reported to her that he fell in his room while putting on his pants. -Resident #2 reported pain in both thumbs and thought he may have broken them. -She called Resident #2's family member and the family member transported Resident #2 to the local emergency department.	D 451		

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-She filled out a Post-Fall report and reported the fall to the Health and Wellness Director (HWD).
-When Resident #2 returned from the local hospital he had splints on both thumbs but did not have broken bones.

Interview with the HWD on 07/10/19 at 4:45 pm revealed:
-She was not aware of an incident in April 2019 or any incidents where Resident #2 fell and went to the hospital for injuries.
-The facility converted to electronic notes in March 2019 and she did not see the fall documented in the electronic notes for April 2019; there was a note dated 04/25/19 for an appointment with an orthopedic physician.
-Resident #2's son frequently took the resident to his appointments.
-Post-Fall reports were completed by the MAs at the time of a fall; the staff would meet after the fall to discuss interventions to minimize the risk of future falls.
-She reported all falls with injuries to the DSS.
-She completed an incident report for each fall with injuries and faxed the reports to DSS; she kept a copy of the report and confirmation of the sent fax.

Interview with Resident #2's family member on 07/11/19 at 11:35 am revealed:
-On 04/23/19 the facility staff called him and told him Resident #2 and reported pain in both hands because of a fall in his room; he took Resident #2 to the emergency room at the local hospital; Resident #2 complained of pain in both thumbs.
-Resident #2 did not have fractures to his hands; the emergency room physician put splints on both thumbs because his thumbs were compressed.

Refer to interview with the Executive Director on

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D 451	Continued From page 57 07/11/19 at 12:30 pm. 2. Review of Resident #1's current FL-2 dated 07/27/18 revealed diagnoses included atrial fibrillation, embolic cerebrovascular accident, hyperlipidemia, hypertension, bilateral lower extremity edema, acute renal failure, and chronic kidney disease. Review of Resident #1's progress notes dated 06/27/19 revealed Resident #1 was responded to on the 11:00 pm to 7:00 am shift due to an unwitnessed fall. Review of Resident #1's hospital discharge summary report dated 07/05/19 revealed: -Resident #1 was admitted to the hospital on 06/28/19 and the admission diagnosis was fall. -Resident #1 was discharged from the hospital on 07/05/19 with the diagnosis of hematoma of the left arm. Review of the facility computerized incident report for Resident #9 revealed: -There was an incident date of 06/27/19 and the incident that occurred was a fall. -There was documentation of a skin tear and soreness for injury and documentation of injury without outside treatment and/or observation. -There were no notification boxes on the report. Interview with Resident #1 on 07/09/19 at 10:40 am revealed: -She fell sometime in June 2019 when she was trying to chase down and kill a cockroach. -She was admitted to the local hospital and they did not do anything for her left arm. -She still had a large knot on her left arm and she had shown her left arm to the facility physician.	D 451		

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D 451	Continued From page 58 Interview with the medication aide (MA) on 07/10/19 at 3:05 pm revealed: -She thought she had completed Resident #1's incident report but was unsure. -She was not responsible for notifying the family member or Department of Social Services (DSS). -The Health and Wellness Director and the Health and Wellness Coordinator were responsible for notifying the family member and DSS. -The MAs completed a handwritten incident report and gave it to the Health and Wellness Director or the Health and Wellness Coordinator. Interview with the Health and Wellness Director on 07/11/19 at 11:45 am revealed: -The MAs completed a incident report form and gave it to her or the Health and Wellness Coordinator. -In June 2019, she would have been the staff who sent the incident reports to the county DSS. -She thought she had sent the incident report for Resident #1 but she needed to check another file. -There was no documentation in the computer verifying the incident report for Resident #1 was sent to the county DSS. Interview with the Health and Wellness Coordinator on 07/11/19 at 12:05 pm revealed she did not send any incident reports to the county DSS in June 2019 because she was still being trained by the Health and Wellness Director. Refer to interview with the Executive Director on 07/11/19 at 12:30 pm. Interview with the Executive Director on 07/11/19 at 12:30 pm revealed: -The MA completed an incident report resident	D 451		

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D 451	Continued From page 59 injuries or incidents that require residents to be hospitalized. -The Health and Wellness Director called or faxed the incident report to the county Department of Social Services (DSS). -The fax verification was kept when the incident reports were faxed to the county DSS and should be in a separate notebook.	D 451		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to treat 2 of 9 residents (#8, #9) with respect and dignity related to not providing assistance or prompting to a resident with vision impairments, who ate their food with their fingers (#8, #9); and rushing a resident to finish her lunch meal (#9). The findings are: 1. Review of Resident #8's current FL-2 dated 09/20/18 revealed: -Diagnoses included dementia with lewy bodies, hypertension, hyperlipidemia, diabetes mellitus, and malignant neoplasm of the prostate. -He was constantly disoriented. -Functional limitations included sight and hearing. -The resident's diet order was carbohydrate controlled.	D911		

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D911	Continued From page 60 Observation of the breakfast meal service on the Special Care Unit (SCU) on 07/10/19 from 8:10am-8:50am revealed: -Resident #8 was seated at a table with three other residents. -He was served a cup of water and orange juice. -He had no silverware or napkin. -At 8:20am, he was served one pancake, one sausage patty, one boiled egg and two orange slices. -Resident #8 ate his pancake with his fingers. -The resident was moving hands his over his plate of food to determine where his food was located on the plate. -Resident #8 placed his orange slices and egg on the edge of the table. -No staff approached Resident #8 to provide assistance. -At 8:44am, the SCU Coordinator placed a set of rolled silverware and napkin next to his plate. -At 8:46am, a personal care aide (PCA), unrolled the silverware and placed the fork in his plate. -At 8:50am, another PCA picked up the orange slices and removed the peel. -The PCA rotated his plate around, but never spoke to the resident. -No staff prompted the resident to tell him what food was served, where his food was on his plate, or provided any feeding assistance. Interview with the SCU Coordinator on 07/10/19 at 8:20am revealed: -The staff did not usually provide silverware to Resident #8. -Since Resident #8 was blind, it was easier for him to feel around his plate. Observation of the lunch meal service on the SCU on 07/10/19 from 11:50am-1:00pm revealed:	D911		

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D911	Continued From page 61 -Resident #8 was seated at the table with three other residents. -A PCA was seated at the table providing assistance to another resident. -Resident #8 was served turkey meatloaf on a bun and steamed cauliflower. -At 12:55pm, the Health and Wellness Director brought a set of rolled silverware to Resident #8 and handed him the spoon; she put a piece of the cauliflower on the fork and handed it to him. -The resident held the fork in his left hand and used his right hand to feel for his food. -He dropped a piece of cauliflower in his lap. -No staff prompted the resident to tell him what food was served, where his food was on his plate or provided any feeding assistance. Interview with a PCA on 07/10/19 at 5:00pm revealed: -The staff would provide cues to Resident #8 by telling hime where the food was on his plate using the clock method. -The staff did not provide him with silverware because he had finger foods. -Resident #8 was able to feed himself and pick up his beverage cups. -Staff told him where the food was on his plate. Interview with the Health and Wellness Director on 07/10/19 at 4:20pm revealed: -Resident #8 had macular degeneration. -He was given a yellow plate a while back to help him see the meal being served. -Her expectation was for staff to tell him where his food was located on his plate; that was the staff had been trained to do. The American Academy of Ophthalmology states that macular degeneration is the leading cause of vision loss in the elderly. It occurs when the	D911		

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D911	Continued From page 62 macular part of the retina is damaged, causing loss of central vision. Fine details can no longer be seen, whether looking at something close or far; peripheral (side) vision remains normal. Interview with the Executive Director on 07/10/19 at 4:25pm revealed: -Her expectation of staff was to utilize the clock method when assisting Resident #8 with meals. -She was not aware staff were not assisting Resident #8 and that he was using his hands to feel around in his plate to locate his food. -The SCU Coordinator was new and may not be aware of Resident #8's condition. Observation of the lunch meal service on 07/11/19 from 12:20pm-12:50pm revealed: -Resident #8 was seated at the table and his meal had not been touched. -He was served sliced fish filet, homestyle potatoes and green peas; he did not have a beverage. -At 12:25pm, the PCA prompted him to eat and told him where each food item was on his plate; the PCA walked away but asked the SCU Coordinator to get Resident #8 something to drink. -At 12:31pm, the SCU Coordinator brought a beverage cup to Resident #8 and told him the cup was next to his plate; Resident #8 picked up the beverage cup. -At 12:40pm, the PCA returned and moved Resident #8's beverage cup, put a potato on his fork, and fed the potato to him. The PCA walked away. -At 12:50pm, Resident #8 was sitting at the table, not eating or feeling for the food on his plate. -No staff approached Resident #8 to assist him with his meal.	D911		

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2. Observation of the noon meal in the Assisted Living dining room on 07/10/19 from 12:00pm - 1:30pm revealed:
-There were 20 tables and 1 table to accommodate feeding assistance.
-There were 52 residents and 2 visitors.
-There were several staff members including certified nursing assistance, caregivers and dietary in the dining room.

Review of Resident #9's current FL2 dated 02/14/17 revealed:
-Diagnoses included chest pain, hip fracture, Gastrointestinal disorder, left extremity edema, history of breast cancer, right bundle branch block.
-She was able to eat independently.

Observation of Resident #9 in the dining room for the noon meal from 12:00pm to 1:10pm:
-At 12:11pm, Resident #9 was seated at the dining room table in a wheel chair eating salad with her hands.
-At 12:21pm, staff took the Resident's meal order.
-The Resident's body was slumped over in her wheelchair.
-The same staff made no attempt to reposition the Resident.
-At 12:22pm Resident #9 continued to eat the salad with her hands.
-At 1:00pm, the same staff returned with her meal.
-At 1:06pm another staff asked Resident #9 if she wanted a take-out tray to take her meal to her room.
-At 1:10pm staff returned with a carry out plate.

Interview with Resident #9 on 07/10/19 at 12:50 pm revealed:
-She ate her salad with her hands because she

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D911	Continued From page 64 could not use a fork, but she was able to eat other foods with a wide handle spoon. -She was not sure if she would prefer assistance with feeding and felt that she needed to understand better what would be done for feeding assistance. -She was not sure of how she felt about the dining room experience. Interview with a personal care aide on 07/10/19 at 12:50pm revealed: -Resident will eat her salad. -Resident eats slow. -Resident will be the last one in the dining room. Interview with the Executive Director on 07/10/19 at 4:38pm revealed: -The facility staff serving in the dining room should allow residents to finish their meals. -The facility staff serving in the dining room should allow resident to ask for a carry out box. -"We should not be asking residents if they want a box." Interview with Kitchen Manager (KM) on 07/11/19 at 8:10am revealed: -The facility staff serving in the dining room should allow residents to eat at their own pace. -She provides monthly trainings on how to properly serve residents in the dining room. _____ The facility failed to treat residents with respect and dignity by not providing cues, prompting or assistance to a resident with visual impairment, who ate his food with his fingers and used his hands to feel for the food in his plate; and approached another resident about getting her lunch meal in a to-go plate after the resident waited over 30 minutes to get her meal after being served a salad. This failure was detrimental	D911		

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D911	Continued From page 65 to the resident's health and well-being and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/10/19 for this violation. THE CORRECTION DATE SHALL NOT EXCEED AUGUST 25, 2019 FOR THE TYPE B VIOLATION.	D911		
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 ensure residents received care and services which were adequate and in compliance with relevant state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 7 sampled residents (#2, #3 and #6) related to medication used to treat mouth sores and a medication used to relieve pain (#6); a medication used to lower	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032065	A. BUILDING: _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DURHAM	4434 BEN FRANKLIN BOULEVARD DURHAM, NC 27704

(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
D912	Continued From page 66 cholesterol (#2); and an anti-flammatory medication and a pain medication (#3). [Refer to Tag D0358, 10A NCAC 13F. 1004(a) Medication Administration (Type B Violation)]. Based on observations, interviews and record reviews, the facility failed to treat 2 of 9 residents (#8, #9) with respect and dignity related to not providing assistance or prompting to a resident with vision impairments, who ate their food with their fingers (#8, #9); and rushing a resident to finish her lunch meal (#9). [Refer to Tag 911 G.S.131D-21(1) Residents' Rights (Type B Violation)].	D912		

August 19, 2019

The following is the Plan of Correction for Brookdale Durham regarding the Statement of Deficiencies dated 7/31/19. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

10A NCAC 13F.0703

The Health and Wellness Director and/or designee will audit all resident records to verify FL2 compliance.

To assist with compliance, the HWD/ED or designee will monitor this process by auditing 10 resident's records weekly for the first month, then bi-weekly for the next month and then randomly thereafter.

10A NCAC 13F.0902

The Health and Wellness Director and/or designee will re-train appropriate staff members on the treatments and orders, and following resident's Plan of Care

The Health and Wellness Director and/or designee will audit all resident records to verify weight policy compliance.

To assist with compliance, the HWD/ED or designee will monitor this process by auditing 10 resident's records weekly for the first month, then bi-weekly for the next month and then randomly thereafter.

10A NCAC 13F.1002

The Health and Wellness Director and/or designee will re-train appropriate staff members on the Medication and Treatment Administration Policy.

The Health and Wellness Director and/or designee will audit all resident records to verify Medication and Treatment Administration policy compliance.

To assist with compliance, the HWD/ED or designee will monitor this process by auditing 10 resident's records weekly for the first month, then bi-weekly for the next month and then randomly thereafter.

10A NCAC 13F.1004

The Health and Wellness Director and/or designee will re-train appropriate staff members on the Medication Administration Policy and proper storage of medications.

The Health and Wellness Director and/or designee will audit all resident records and medication carts to verify Medication Administration Policy compliance.

To assist with compliance, the HWD/ED or designee will monitor this process by auditing 10 resident's records weekly for the first month, then bi-weekly for the next month and then randomly thereafter. **The correction date for rule 10 NCAC 13F.1004 is 8/25/19**

10 A NCAC 13F. 1006

The Health and Wellness Director and/or designee will re-train appropriate staff members on the Medication Administration Policy and Procedure and proper storage of medications.

To assist with compliance, the HWD/ED or designee will monitor this process weekly for the first month, then bi-weekly for the next month and then randomly thereafter.

10A NCAC 13F.1212

The Health and Wellness Director and/or designee will re-train appropriate staff members on the Incident Report Policy.

Accidents or incidents resulting death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid will be reported to DSS. This notification will be within 48 hours of the incident or accident.

To assist with compliance, the HWD/ED or designee will monitor this process weekly for the first month, then bi-weekly for the next month and then randomly thereafter.

G.S. 131D-21(1)

The Executive Director and/or designee will re-train appropriate staff members on Resident Rights.

To assist with compliance, the ED or designee will monitor this process weekly for the first month, then bi-weekly for the next month and then randomly thereafter.

The correction date for rule G.S. 131D- 21 is 8/25/19

10A NCAC 13F. 0306

The Maintenance Manager and/or designee will retrain appropriate staff members on cleaning procedures.

To assist with compliance, the Maintenance Manager and /or designee will monitor this process on an ongoing basis.

10A NCAC 13F. 0311

The Maintenance Manager and/or designee will monitor the necessary equipment for proper operation.

The Maintenance Manager and/or designee will do water temperature audits weekly for the first month, then bi-weekly for the next month and then randomly thereafter.

10 NCAC 13F .0904 (a)

The Dining Service Manager and/or designee will retrain appropriate staff members on cleaning procedures.

The Dining Services Manager and/or designee will provide monthly in- services with the appropriate staff.

To assist with compliance, the Dining Services Manager and /or designee will monitor this process weekly for the first month, then bi-weekly for the next month and then random thereafter.

10 NCAC 13F. 0904 (b)

The Executive Director/Dining Services Manager and/or designee will retrain appropriate staff members on seating of residents in the dining room.

To allow more mobility in the dining area staff will also utilize the garden kitchen area for seating of residents.

To assist with compliance, the Executive Director/Dining Services Manager and /or designee will monitor this process on an ongoing basis.

Date of compliance October 21,2019