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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Cabarrus County Department of Social Services conducted an annual survey and complaint investigation on February 26-27, 2020. | D 000 | The following is the Plan of Correction for **Brookdale Concord Parkway.** This Plan of Correction is in regards to the Statement of Deficiencies dated **February 27, 2020.** 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. | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents receiving a medication for liver disease, a breathing treatment for wheezing, a nasal spray for allergies and a foot pad for pain relief (Resident #1).<br><br>The findings are:<br><br>1. Review of Resident #1's current FL2 dated 09/05/19 revealed diagnoses included chronic atrial fibrillation, pulmonary hypertension, chronic respiratory failure with hypoxia, atrial fibrillation and heart failure.<br><br>a. Review of Resident #1's subsequent physician order dated 11/14/19 revealed:<br>-There was an order for ursodiol 500mg twice daily. | D 358 | | |



Reviewed and Acknowledged Karen M. Polce 04/01/20

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| D 358 | Continued From page 1<br>-Ursodiol is a bile acid used to treat primary biliary cirrhosis, recently diagnosed.<br><br>Review of Resident #1's December 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry for ursodiol 500mg to be administered twice a day at 9:00am and 9:00pm.<br>-There was documentation ursodiol was administered from 12/01/19 through 12/31/19 at 9:00am and 9:00pm.<br><br>Review of Resident #1's January 2020 eMAR revealed:<br>-There was an entry for ursodiol 500mg to be administered twice a day at 9:00am and 9:00pm.<br>-There was documentation ursodiol was administered from 01/01/20 through 01/31/20 at 9:00am and 9:00pm.<br><br>Review of Resident #1's February 2020 eMAR revealed:<br>-There was an entry for ursodiol 500mg to be administered twice a day at 9:00am and 9:00pm.<br>-There was documentation ursodiol was administered from 02/01/20 through 02/27/20 at 9:00am and 9:00pm.<br><br>Telephone interview with the facility's contracted pharmacist on 02/27/20 at 8:59am revealed:<br>-Ursidiol 500mg was originally sent to the facility on 11/14/19 for Resident #1 as a new order.<br>-The fill history for Resident #1's ursidiol was as follows:<br>-On 11/14/19 60 tablets of ursidiol 500mg, a 15 day supply, was sent to the facility.<br>-On 12/09/19 60 tablets of ursidiol 500mg, a 15 day supply, was sent to the facility.<br>-On 12/24/19 no ursidiol tablets were sent. The pharmacy informed the facility the medication | D 358 | Rule 10A NCAC 13F.1004(a) Medication Administration<br>The Health and Wellness Director will in service the medication techs, the Resident Care Coordinator and the Health and Wellness Coordinators on the new order tracking, how to do a cart audit and Brookdale medication administration policy.<br>*Per T Schick ED this will be completed by 04/10/20<br>The Health and Wellness Director will assist with medication management by monitoring the new order tracking daily for 3 weeks.<br><br>The Health and Wellness Coordinators will audit the med carts weekly.<br><br>The Health and Wellness Director will complete one cart audit weekly.<br>*Per T Schick ED this will be completed by 04/10/20 | KP 4/1/20<br><br>KP 4/1/20 |

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| D 358 | Continued From page 2<br>was on back order.<br>-On 01/04/20 60 tablets of ursidiol 500mg, a 15 day supply, was sent to the facility.<br>-On 01/29/20 60 tablets of ursidiol 500mg, a 15 day supply, was sent to the facility.<br>-The facility's medications were not on a monthly cycle fill.<br>-Medication refills would be faxed or called in to the pharmacy by the facility staff.<br>-The pharmacy's Clinical Intervention team called the facility and sent a fax to the facility to inform them of the backorder of ursidiol.<br>-It was the responsibility of the facility staff to contact the prescribing physician and request an order to hold the medication or request an alternative medication.<br>-The Clinical Intervention team did not contact the prescribing physician.<br>-According to the fill history, Resident #1's ursidiol 500mg tablets, from 11/29/19 through 12/09/19, were not available for administration for 10 days, 20 tablets.<br>According to the fill history, Resident #1's ursidiol 500mg tablets, from 12/24/19 through 01/04/20, were not available for administration for 10 days, 20 tablets.<br><br>Interview with Resident #1's primary care physician (PCP) on 02/27/20 at 8:20am revealed:<br>-She had ordered routine laboratory tests for Resident #1 in October 2019.<br>-Resident #1's liver function studies were abnormal and the PCP referred the resident to a gastroenterologist (GI) in November 2019.<br>-The GI physician diagnosed biliary cirrhosis at the 11/13/19 visit and prescribed ursediol twice a day and follow up laboratory tests in 3 months.<br>-The GI physician was out of the office this week.<br>-The PCP expected all orders would be administered by the facility as directed by the | D 358 | | |

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| D 358 | Continued From page 3<br>prescribing physician.<br>-She had not been notified by the facility of any medications back ordered or not delivered by the pharmacy.<br><br>Interview with a first shift medication aide (MA) on 02/26/ 20 at 3:10pm revealed:<br>-The MAs were responsible to order refill medications when there were 5 or less tablets in the blister pack or bottle.<br>-Medication refills could be ordered on the medication cart laptop, or faxing the pharmacy staff with the medication label removed from the blister pack.<br>-If the medication requested did not arrive at the facility by the next day, the MA would call the pharmacy and follow up.<br>-She did not remember Resident #1's ursidiol tablets not available for administration in December 2019 or January 2020.<br><br>Interview with the Resident Care Coordinator (RCC) on 02/27/20 at 3:30pm revealed:<br>-Weekly cart audits were completed by the MAs and the RCC.<br>-The eMARS were printed for each resident on the cart and compared to the medications on hand.<br>-The MAs were responsible for assuring the "as needed" (PRN) medications were on the cart.<br>-The RCC checked the open dates and the expiration dates of the medications weekly.<br>-The completed cart audit forms were submitted to the Health and Wellness Coordinator (HWC).<br>-She could not recall the last date she had audited the medication carts.<br>-If a medication was back ordered the pharmacy notified the prescribing physician.<br>-The facility staff did not notify the physician if a medication was not available for administration. | D 358 | | |

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| D 358 | Continued From page 4<br>-The pharmacy should have notified the physician that the ursidiol was back ordered and not available for administration.<br><br>Interview with the HWC on 02/27/20 at 3:45pm revealed:<br>-She reviewed the weekly cart audit sheets submitted by the MAs.<br>-Not all the MAs submitted the completed cart audit sheets.<br>-She did not know if that meant the MAs did not complete the cart audit.<br>-The MAs should be comparing the eMARS to the medications available for administration.<br>-She was not informed ursidiol was not in the building for 10 days from 11/28/19-12/09/19 and 10 days from 12/25/19-01/04/20.<br>-It is the MAs responsibility to order medications for the Residents.<br>-She could not speak for the MAs as to why the medication was not available for administration.<br>-The MAs reported to the HWC, and she trained them as to the process of completing a cart audit and ordering medications.<br><br>Interview with the Resident Care Director (RCD) on 02/27/20 at 12:00pm revealed:<br>-The RCC and the HWC were responsible for physician orders and treatments, cart audits, medication delivery and medical appointments.<br>-The HWC reviewed new orders and ensured their correct entry on the eMARS.<br>-She did not know Resident #1's ursidiol medication was not available for administration 10 days from 11/28/19-12/09/19 and 10 days from 12/25/19-01/04/20.<br><br>Interview with the Administrator on 02/27/20 at 2:35pm revealed:<br>-The MAs were responsible for ordering | D 358 | | |

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| D 358 | Continued From page 5<br>medications and resident supplies from the pharmacy.<br>-The RCC and the HWC should be notified if the MAs had not received the proper medication or were not receiving the medication in a timely manner.<br>-Medications were delivered to the facility on third shift and the MAs placed them on the appropriate medication cart.<br>-The MAs and RCC should be completing weekly cart audits to ensure medications were available for administration.<br>-He did not know there were medications that were not in the building available for administration.<br>-He did not know Resident #1's physician was not notified she had missed ursediol for 10 days from 11/28/19-12/09/19 and 10 days from 12/25/19-01/04/20.<br><br>Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.<br><br>b. Review of Resident #1's FL2 dated 09/05/19 revealed an order for ipatropium albuterol 0.5-3mg nebulization 1 vial every 4 hours as needed for wheezing.<br><br>Review of Resident #1's December 2019 electronic Medication Administration Record (eMARs) revealed:<br>-There was an entry for ipatropium albuterol 0.5-3mg nebulization 1 vial every 4 hours to be administered as needed for wheezing.<br>-There was no documentation ipatropium albuterol 0.5-3mg nebulization as needed was administered from 12/01/19 through 12/31/19<br><br>Review of Resident #1's January 2020 eMARs | D 358 | | |

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| D 358 | Continued From page 6<br>revealed:<br>-There was an entry for ipatropium albuterol 0.5-3mg nebulization 1 vial every 4 hours to be administered as needed for wheezing.<br>-There was no documentation ipatropium albuterol 0.5-3mg nebulization as needed was administered from 01/01/20 through 01/31/20.<br><br>Review of Resident #1's February 2020 eMARS revealed:<br>-There was an entry for ipatropium albuterol 0.5-3mg nebulization 1 vial every 4 hours to be administered as needed for wheezing.<br>-There was no documentation ipatropium albuterol 0.5-3mg nebulization as needed was administered from 02/01/20-02/27/20.<br><br>Observation of Resident #1's medications on hand revealed there were no vials of ipatropium albuterol 0.5-3mg available for administration.<br><br>Telephone interview with the facility's contracted pharmacy on 02/27/20 at 8:59am revealed:<br>-Resident #1's order for ipatropium albuterol 0.5-3mg nebulization 1 vial every 4 hours to be administered as needed for wheezing was a current order.<br>-The fill history for the ipatroprium albuterol indicated it had not been filled "in greater than a year."<br><br>Interview with Resident #1's primary care physician (PCP) on 02/27/20 at 8:20am revealed:<br>-Resident #1 had chronic hypoxia and chronic pulmonary edema.<br>-She had not observed any wheezing during her monthly visit, but she wanted the order to be continued due to her diagnoses.<br>-She expected medications, including as needed medications (PRNs), to be available for | D 358 | | |

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| D 358 | Continued From page 7<br>administration.<br><br>Interview with the Resident Care Coordinator (RCC) on 02/27/20 at 3:30pm revealed:<br>-Weekly cart audits were completed by the Medication Aides (MAs) and the RCC.<br>-The eMARS were printed for each resident on the cart and compared to the medications on hand.<br>-The MAs were responsible for ensuring the PRN medications were available for administration.<br>-She did not know why an order on the eMAR did not have the corresponding medication available for administration.<br>-It was the responsibility of the MAs to order medications that were not available for administration.<br>-She did not know why the MAs did not order Resident #1's ipatropium albuterol 0.5-3mg nebulization.<br><br>Interview with the second shift MA on 02/27/20 at 3:15pm:<br>-She had not completed a cart audit since she was hired last month.<br>-She did not know ipatroprium albuterol was not available for administration because Resident #1 had not requested it.<br>-She was not sure how medications were ordered from the pharmacy.<br><br>Interview with the Administrator on 02/27/20 at 2:35pm revealed:<br>-The RCC and Health and Wellness Coordinator (HWC) were responsible for overseeing the delegation of the cart audits to the MAs.<br>-Active orders on the eMARs should have the corresponding medications available for administration.<br>-He did not know Resident #1's ipatropium | D 358 | | |

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| D 358 | Continued From page 8<br>albuterol 0.5-3mg nebulization was not available for administration as needed.<br><br>c. Review of Resident #1's FL2 dated 09/05/19 revealed an order for flonase 50mcg spray once in each nostril every 24 hours for allergies.<br><br>Review of Resident #1's December 2019 electronic Medication Administration Record (eMARs) revealed:<br>-There was an entry for flonase 50mcg one spray in each nostril every 24 hours for allergies.<br>-There was no documentation flonase spray was administered from 12/01/19 through 12/31/19.<br><br>Review of Resident #1's January 2020 eMARs revealed:<br>-There was an entry for flonase 50mcg one spray in each nostril every 24 hours for allergies.<br>-There was no documentation flonase spray was administered from 01/01/20 through 01/31/20.<br><br>Review of Resident #1's February 2020 eMARS revealed:<br>-There was an entry for flonase 50mcg one spray in each nostril every 24 hours for allergies.<br>-There was no documentation flonase spray was administered from 02/01/20 through 02/27/20.<br><br>Observation of Resident #1's medications on hand on 02/26/20 at 3:10pm revealed there was no flonase spray available for administration.<br><br>Telephone interview with the facility's contracted pharmacy on 02/27/20 at 8:59am revealed:<br>-Resident #1's Flonase 50mcg spray once in each nostril every 24 hours for allergies was a current order.<br>-The Flonase spray was last filled on 05/30/19. | D 358 | | |

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| D 358 | Continued From page 9<br><br>Interview with Resident #1's primary care physician (PCP) on 02/27/20 at 8:20am revealed:<br>-Resident #1 consistently complained of a runny nose.<br>-She had prescribed flonase 1 spray in each nostril every day as needle for allergies.<br>-It was the only consistent complaint Resident #1 expressed to her.<br>-She would expect the flonase spray to be available when Resident #1 needed it for her runny nose.<br><br>Interview with the Resident Care Coordinator (RCC) on 02/27/20 at 3:30pm revealed:<br>-Weekly cart audits were completed by the MAs and the RCC.<br>-The Medication Aides (MAs) were responsible for ensuring the "as needed" (PRN) medications were on the cart.<br>-She did not know why an order on the eMAR did not have the corresponding medication available for administration.<br>-It was the responsibility of the MAs to order medications that were not available for administration.<br>-She did not know Resident #1's flonase spray was not available for administration and had not been ordered from the pharmacy.<br><br>Interview with the second shift MA on 02/27/20 at 3:15pm:<br>-She had not completed a cart audit since she was hired last month.<br>-She did not know flonase nasal spray was not available for administration.<br>-She was not sure how medications were ordered from the pharmacy.<br><br>Interview with the Administrator on 02/27/20 at 2:35pm revealed: | D 358 | | |

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| D 358 | Continued From page 10<br>-The RCC and HWC were responsible for overseeing the delegation of the cart audits to the MAs.<br>-Active orders on the eMARs should have the corresponding medications available for administration.<br>-He did not know Resident #1 did not have flonase 50mcg spray for her allergies available for administration.<br><br>d. Review of Resident #1's physician order dated 02/03/20 revealed an order for a silicone foot pad to the right forefoot, apply in the morning with shoes and remove in the evening.<br><br>Review of Resident #1's February 2020 electronic Medication Administration Record (eMARS) revealed:<br>-There was an entry for silicone pads apply to the right forefoot with shoes at 8:00am and remove in the evening at 3:59pm.<br>-There was documentation the silicone foot pad was applied to the right forefoot 18 out of a possible 21 times at 8:00am.<br>-There was documentation the silicone foot pad was removed 16 out of a possible 20 times at 3:59pm..<br>-There was electronic documentation on 02/05/20, 02/08/20, 02/12/20, 02/14/20, 02/22/20, and 02/23/20 the Medication Aides (MAs) recorded "waiting on pharmacy."<br>-There was electronic documentation on 02/25/20 Resident #1 complained of foot pain. The MA administered PRN acetaminophen for pain relief.<br><br>Observation of Resident #1's right foot in her bedroom on 02/26/20 at 2:45pm revealed:<br>-There was a quarter size discolored area on Resident #1's right forefoot.<br>-There was no silicone gel pad on the area or in | D 358 | | |

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| D 358 | Continued From page 11<br>her stocking.<br>-There was a Dr Scholl heel pad in her right sneaker.<br><br>Observation of Resident #1's medications on hand on 02/26/20 at 3:10pm revealed there were no silicone pads for the right forefront of the foot.<br><br>Interview with the first shift MA on 02/26/20 at 3:20pm revealed:<br>-She did not know why there was an order for Resident #1 to have silicone pads on her foot.<br>-She did not know why they were not on the cart.<br>-The silicone pads may be in her room.<br>-She could not remember if she had applied the silicone pad to Resident #1's right forefoot that morning.<br><br>Telephone interview with the facility's contracted pharmacist on 02/27/20 at 8:59am revealed:<br>-An order was sent from the facility on 02/03/20 for a silicone foot pad to right forefoot, apply in the morning with shoes and remove in the evenings, for Resident #1.<br>-On 02/03/20 two Dr Scholl Heel cushions were sent for Resident #1.<br>-No additional pads have been sent to the facility for Resident #1.<br>-He did not know why heel pads were sent for the forefoot.<br><br>Observation of Resident #1's right sneaker on 02/27/20 at 11:40am revealed a heel insert placed in the sneaker at the heel position.<br><br>Interview with the prescribing physician on 02/27/20 at 5:00pm revealed:<br>-Resident #1 had a calloused area on the ball of her right foot below the 5th toe.<br>-Resident #1 ambulated frequently in the | D 358 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL013019 | A. BUILDING: _____ B. WING _____ | 02/27/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE CONCORD PARKWAY | 2452 ROCK HILL CHURCH ROAD NW CONCORD, NC 28027 |

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| D 358 | Continued From page 12<br>community with her rollator and was experiencing some pain and discomfort.<br>-She pared the area down and ordered a silicone gel pad to place over the sensitive area to reduce the pain and discomfort.<br>-She wanted to ensure Resident #1 continued to ambulate in the community.<br>-If she complained of foot pain in that area she would benefit from the protection of the silicone pad.<br>-The heel insert did not facilitate the goal of reducing pain to the area on ambulation.<br><br>Interview with the Health and Wellness Coordinator (HWC) on 02/27/20 at 3:45pm revealed:<br>-When a new order was prescribed by a physician, the medication aide (MA) entered the order into the "Point and Click" system.<br>-The supervisor checked behind the MA to ensure the order was entered correctly.<br>-The MA also entered the order on the New Order tracking form.<br>-The HWC generated a report weekly on new orders and progress notes.<br>-She reviewed the new order and the eMAR entry.<br>-She did not remember entries from the MAs 02/05/20, 02/08/20, 02/12/20, 02/14/20, 02/22/20, and 02/23/20 that recorded "waiting on pharmacy."<br>-She had observed the heel insert in Resident #1's sneaker.<br>-The MAs did not inform her the Dr Scholl's heel insert was sent instead of silicone gel pads to be applied to the fore foot.<br><br>Interview with the Administrator on 02/27/20 at 2:35pm revealed:<br>-The MAs were responsible for ordering | D 358 | | |

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|---|---|---|---|---|
| D 358 | Continued From page 13<br>medications and resident supplies from the pharmacy.<br>-The RCC and the HWC should be notified if the MAs have not received the proper medication or supplies from the pharmacy.<br>-Medications were received at the facility on third shift and the MAs place them on the appropriate medication cart.<br>-The MAs and RCC should be completing weekly cart audits to ensure medications were available for administration.<br>-He did not know there were medications that were not in the building available for administration.<br>-He did not know Resident #1's silicone gel pad to protect a callous area recently scraped by the physician had not been received or administered. | D 358 | | |