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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 02/09/22 to 02/11/22.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure the primary care provider was notified for 1 of 5 sampled residents related to the refusal by resident to have bloodwork drawn and failing to make an eye appointment (Resident #3). Review of Resident #3's current FL2 dated 02/09/21 revealed diagnoses included Alzheimer's disease, hypothyroidism, hypertension, chronic gout and heart failure. a. Review of Resident #3's record revealed: -There was an order dated 12/20/21 for bloodwork to check B12 level and uric acid level. -There was an order dated 01/05/22 for bloodwork to check complete metabolic panel (CMP), Vitamin D level and a complete blood count (CBC). -There was no documentation of completed bloodwork available for review. -There was a consultation note dated 01/17/22 from Resident #3's PCP documenting labs were not available for review and she sent an email to the lab for an update or results. Interview with the Health and Wellness Director	D 273		

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(HWD) on 02/11/22 at 11:30am and 2:10pm revealed:
-Bloodwork to check Uric Acid levels, Vitamin B12 levels, CMP, CBC and Vitamin D levels were not completed because Resident #3 refused three times to have the bloodwork drawn.
-She did not know if the PCP was informed of the refusals.

Interview with the Administrator on 02/11/22 at 3:54pm revealed:
-She was not aware Resident #3 was ordered bloodwork on 12/20/21 and 01/05/22.
-She expected staff to inform the PCP if bloodwork was not completed as ordered.

Attempted telephone interview with the facility's contracted Home Health agency on 02/11/22 at 4:54pm was unsuccessful.

Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable.

Refer to Interview with the Resident Care Coordinator on 02/10/22 at 9:45am.

b. Review of Resident #3's record revealed:
-There was an order dated 12/20/21 for an eye appointment to monitor glaucoma.
-There was no documentation an eye appointment was made or completed.

Interview with the Health and Wellness Director (HWD) on 02/11/22 at 11:30am revealed she did not know if an eye appointment had been scheduled.

Telephone interview with the appointment coordinator at Resident #3's eye physician's office

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D 273	Continued From page 2 on 02/11/22 at 3:31pm revealed Resident #3 did not have an eye appointment scheduled during December 2021, January 2022 or February 2022. Interview with the Administrator on 02/11/22 at 3:54pm revealed she did not know until today (02/11/22) that an eye appointment was ordered on 12/20/21. Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable. Refer to Interview with the Resident Care Coordinator on 02/10/22 at 9:45am. _____ Interview with the Resident Care Coordinator (RCC) on 02/10/22 at 9:45am revealed: -She started a binder for orders on 02/08/22 because the facility discovered they were having problems with referrals and orders being missed. -The medication aides now documented resident refusals on a shift report sheet so she could follow up with the orders. -She was responsible for ensuring orders were completed.	D 273		
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.	D 276		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure physician's orders were implemented for 1 of 5 sampled residents (#4) with an order for a urinalysis.

The findings are:

Review of Resident #4's current FL2 dated 12/28/21 revealed:
-Diagnoses included dementia with behaviors.
-Resident #4 was constantly disoriented and incontinent of bladder.

Review of Resident #4's physician's order dated 02/01/22 revealed an order for a urinalysis with culture and sensitivity if indicated.

Review of Resident #4's lab work results revealed there were no results available for a completed urinalysis.

Interview with the Resident Care Coordinator (RCC) on 02/10/22 at 9:45am revealed:
-A urine specimen was not collected and sent to the lab for Resident #4 because Resident #4 was sick the day the urinalysis was ordered, and staff were unable to collect a sample.
-Resident #4 would not allow staff to collect a urine sample on 02/03/22 and she did not know why a urine sample had not been collected since then.
-The medication aides (MA's) were responsible for collecting urine samples.
-She started a binder for orders on 02/08/22 because the facility was having problems with referrals and orders being missed.
-The MA was responsible for documenting resident refusals on a shift-to-shift report sheet and she or the Health and Wellness Director

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D 276	Continued From page 4 would follow-up with the orders. -She was responsible for ensuring orders were completed. Interview with a MA on the Special Care Unit (SCU) on 02/10/22 at 11:05am revealed: -She tried for approximately 20 minutes to get Resident #4's urine sample "last week" but could not get one because Resident #4 did not want for her to "see him". -She verbally informed either the RCC or Health and Wellness Director she was unable to collect a urine sample for Resident #4. Telephone interview with Resident #4's Primary Care Provider (PCP) on 02/10/21 at 1:30pm revealed: -She was not notified by the facility Resident #4's urinalysis was not completed. -She ordered a urinalysis for Resident #4 to check for a urinary tract infection since he had displayed increased behavioral issues. -She expected the facility to complete orders made for residents. Interview with the Administrator on 02/10/22 at 3:15pm revealed: -She did not know a urinalysis was ordered for Resident #4 on 02/02/22. -She expected staff to follow orders for residents or notify the PCP if something was not completed. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 5 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, record reviews, and interviews, the facility failed to administer medications as ordered for 4 of 6 sampled residents (#1, #2, #3, and #6) related to a rapid-acting insulin to control high blood sugar levels (#1), a medication used to treat tremors, stiffness, and difficulty with movement (#6), medications used to treat fluid retention and anxiety (#2), and medications used to treat depression and pain (#3). The findings are: 1. Review of Resident #1's current FL2 dated 11/22/21 revealed: -Diagnoses included type 2 diabetes mellitus with complications and dementia. -There was an order for Novolog 100 units (used to treat diabetes), 5 units every 4 hours as needed for a glucose reading greater than 200. -There was an order to check blood sugars before meals and at bedtime. Telephone interview with a representative from the facility's contracted pharmacy on 02/11/22 at 4:30pm revealed:	D 358		

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-Resident #1's current insulin order was Novolog 100 units, 5 units every 4 hours as needed with blood sugar readings greater than 200.
-Resident #1's Novolog insulin was last dispensed on 01/11/22.

Review of Resident #1's December 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check blood sugars before meals and at bedtime.
-There was an entry for Novolog 100 units, 5 units every 4 hours as needed if the blood sugar reading was greater than 200.
-There were 49 opportunities with blood sugars greater than 200.
-There were 14 instances between 12/01/21 through 12/31/21 where blood sugars were greater than 200, ranging from 202 to 349, and the Novolog 5 units was not administered.

Review of Resident #1's January 2022 eMAR revealed:
-There was an entry to check blood sugars before meals and at bedtime.
-There was an entry for Novolog 100 units, 5 units every 4 hours as needed if the blood sugar reading was greater than 200.
-There were 75 opportunities with blood sugars greater than 200.
-There were 24 instances between 01/02/22 through 01/24/22 where blood sugars were greater than 200, ranging from 205 to 512, and the Novolog 5 units was not administered.

Review of Resident #1's February 2022 eMAR revealed:
-There was an entry to check blood sugars before meals and at bedtime.
-There was an entry for Novolog 100 units, 5

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units every 4 hours as needed if the blood sugar reading was greater than 200.
-There were 11 opportunities with blood sugars greater than 200.
-There were 5 instances between 02/01/22 through 02/05/22 where blood sugars were greater than 200, ranging from 212 to 280, and the Novolog 5 units was not administered.

Interview with a medication aide (MA) on 02/10/22 at 12:20pm revealed:
-She knew Resident #1 had an order to administer Novolog insulin 5 units every four hours as needed when the blood sugar readings were greater than 200.
-She did not always administer insulin to Resident #1 when the blood sugar readings were greater than 200 because Resident #1's blood sugar ran low sometimes.
-She did not think Resident #1 needed the insulin each time the blood sugar reading was greater than 200 because the blood sugar level would "usually drop" below 200 within an hour.
-She did not notify Resident #1's PCP when she withheld administering Resident #1's insulin as ordered.

Interview with the Administrator on 02/10/22 at 4:30pm revealed:
-She did not know the PCP wrote an order to administer Resident #1 Novolog 5 units every 4 hours as needed for blood sugar readings greater than 200.
-She did not know some of the facility staff had not administered insulin as ordered to Resident #1.
-She was a Registered Nurse (RN) and taught diabetic training to facility staff.
-The facility received orders for sliding scale insulin to be administered to residents.

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-She expected staff to follow physician's orders and administer insulin as ordered.
-The MAs should have called to notify the PCP when they did not administer Novolog insulin as ordered to Resident #1 when the blood sugars were greater than 200.

Telephone interview with the Primary Care Provider (PCP) on 02/10/22 at 1:30pm revealed:
-Resident #1 was a brittle diabetic and most of the resident's blood sugar readings were too high.
-She worked hard to get Resident #1's blood sugars controlled.
-The facility did not notify her they had withheld so many doses of insulin when Resident #1's blood sugar reading was greater than 200.
-The missed doses of Novolog insulin would explain why Resident #1's A1C (a blood test that measures the average blood sugar levels over the past 3 months) increased to 10.7% from a previous A1C of 9.8% (normal level is below 5.7%).
-She ordered Novolog 5 units every 4 hours as needed when the blood sugar reading was greater than 200 because the facility told her it was against their policy to use sliding scale insulin orders.
-She expected the facility staff to follow Resident #1's orders and administer Novolog insulin when Resident #1's blood sugar readings were greater than 200.
-It was important for Resident #1's blood sugars to be controlled because it placed Resident #1 at greater risk for infection, diabetic retinopathy (a complication of diabetes which can lead to blindness), and chronic kidney disease.

Based on observation, interviews, and record reviews it was determined Resident #1 was not interviewable.

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Refer to the facility's Medication Administration Policy dated 06/2020.

2. Review of Resident #2's current FL2 dated 09/20/21 revealed diagnoses included atrial fibrillation and anxiety.

a. Interview with Resident #2 on 02/09/22 at 9:47am revealed:
-Over the past weekend she did not receive a medication she took for depression or paranoia because the facility ran out of it.
-She did not sleep well without the medication.

Review of Resident #2's Primary Care Provider (PCP) orders dated 10/04/21 revealed there was an order for thiothixene 1mg (used to treat anxiety) at bedtime.

Review of Resident #2's December 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for thiothixene 1mg at bedtime for anxiety.
-Thiothixene 1mg at bedtime was documented as not administered on 12/05/21 due to "pharmacy action required".

Review of Resident #2's February 2022 eMAR revealed:
-There was an entry for thiothixene 1mg at bedtime for anxiety.
-Thiothixene 1mg at bedtime was documented as not administered 02/04/22 through 02/06/22 due to "pharmacy action required".

Observation of Resident #2's medication on hand on 02/10/22 at 11:08am revealed:
-There were 27 thiothixene 1mg available for

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administration.
-The bubble pack with 30 pills was dispensed 02/07/22.

Telephone interview with a pharmacy technician from Resident #2's pharmacy on 02/10/22 at 10:13am revealed:
-The pharmacy only refilled prescriptions upon request from the facility.
-The pharmacy was not open nor made deliveries on Sunday.
-The pharmacy was open but did not deliver on Saturdays.
-The pharmacy accepted refill requests until 2:00pm on Friday for a Friday delivery.
-There were 30 thiothixene 1mg delivered on Monday 12/06/21 and on Monday 02/07/22 after a fax from the facilty requesting a refill was received and processed when they reopened after the weekend.

Interview with a medication aide (MA) on 02/10/22 at 3:40pm revealed:
-She sent a fax to Resident #2's pharmacy on Friday 02/04/22, in the evening, requesting a refill for thiothixene 1mg but the fax did not go through successfully.
-She sent the fax again on Saturday 02/05/22 at 10:07pm but it was after the pharmacy closed and she knew the medication would not be delivered until Monday.
-She should have faxed the request earlier in the week, but she was busy and never got around to it.
-The normal procedure was to fax a refill request when there were about 7 doses left.

Telephone interview with Resident #2's Primary Care Provider (PCP) on 02/10/22 at 1:11pm revealed:

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-Resident #2's thiothixene was ordered for anxiety.
-Resident #2 experienced increased anxiety or trouble sleeping if she missed a dose of thiothixene.
-She expected the facility to administer medications as ordered,

Interview with the Administrator on 02/10/22 at 4:21pm revealed:
-MAs were trained to order medications before they ran out.
-She did not know Resident #2 was not administered thiothixene over the past weekend (February 4-6, 2022) or on 12/05/21.
-MAs were trained on ordering procedures and she expected them to follow the proper ordering procedures.
-Resident #2's family did not want to use any other pharmacy so there was no back up pharmacy available.

Refer to the facility's Medication Administration Policy dated 06/2020.

b. Review of Resident #2's Primary Care Provider (PCP) orders dated 10/04/21 revealed:
-There was an order for daily weights in the morning and to give Lasix as needed for weight gain.
-There was an order for Lasix 20mg (used for fluid retention) if there was a weight gain of 3 pounds in 1 day or 5 pounds in 1 week.

Review of Resident #2's January 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for daily weights in the morning and to give Lasix as needed for weight gain.

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-There was an entry for Lasix 20mg for weight gain of 3 pounds in 1 day or 5 pounds in 1 week.
-There was documentation Resident #2's weight was 134.2 pounds on 02/03/22 and 138.2 pounds on 02/04/22 reflecting a gain of 4 pounds in 1 day.
-There was no documentation lasix 20mg was administered on 02/04/22.
-There was documentation Resident #2's weight was 134.3 pounds on 02/01/22 and 141.4 pounds on 02/08/22 reflecting a gain of 7.1 pounds in 1 week.
-There was no documentation Lasix 20mg was administered on 02/08/22.

Observation of Resident #2's medication on hand on 02/10/22 at 11:08am revealed Lasix 20mg was available for administration.

Telephone interview with medication aide (MA) on 02/10/22 at 10:31am revealed:
-She did not administer Lasix to Resident #2 in February 2022.
-She did not remember Resident #2 had orders for Lasix if she gained 3 pounds in 1 day or 5 pounds in a week because she did not need it very often.

Telephone interview with Resident #2's Primary Care Provider (PCP) on 02/10/22 at 1:11pm revealed:
-Resident #2 was ordered Lasix for weight gain associated with congestive heart failure.
-Not administering Lasix as ordered for weight gain can exacerbate her congestive heart failure and result in shortness of breath, a significant problem.

Interview with the Administrator on 02/10/22 at 4:21pm revealed:

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-She did not know Lasix was not being administered as ordered for weight gain.
-She expected the MAs to administer medications as prescribed.

Refer to the facility's Medication Administration Policy dated 06/2020.

3. Review of Resident #6's current FL2 dated 06/01/21 revealed:
-Diagnoses included Parkinson's disease.
-There was an order for carbidopa-levodopa ER (used to treat symptoms of Parkinson's disease) 25-100mg 1 tablet daily at bedtime.
-There was an order for carbidopa-levodopa 25-100mg 1 tablet daily at bedtime.
-There was an order for carbidopa-levodopa 25-100mg 2 tablets three times a day at 8:00am, 12:00pm, and 4:00pm.

Interview with Resident #6 on 02/09/22 at 9:45am and on 02/11/22 at 10:00am revealed:
-The resident took carbidopa-levodopa to control symptoms of Parkinson's four times a day.
-Staff administered doses of the carbidopa-levodopa "an hour to an hour and a half" past scheduled administration times.
-The resident felt "weak" when the medication was not administered close to the scheduled administration times.

Review of Resident #6's Primary Care Provider (PCP) orders dated 10/04/21 revealed:
-There was an order for carbidopa-levodopa ER 25-100mg 1 tablet daily at 8:00pm.
-There was an order for carbidopa-levodopa 25-100mg 1 tablet daily at 8:00pm.
-There was an order for carbidopa-levodopa 25-100mg 2 tablets three times a day at 8:00am, 12:00pm, and 4:00pm.

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BROOKDALE FOREST CITY	493 PINEY RIDGE ROAD FOREST CITY, NC 28043

(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 358	Continued From page 14 Review of Resident #6's January 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for carbidopa-levodopa ER 25-100mg one tablet daily scheduled at 8:00pm. -There was an entry for carbidopa-levodopa 25-100mg one tablet daily scheduled at 8:00pm. -There was an entry for carbidopa-levodopa 25-100mg two tablets three times a day scheduled at 8:00am, 12:00pm, and 4:00pm. -The carbidopa-levodopa ER was documented as administered daily at 8:00pm from 01/01/22 to 01/31/22. -The carbidopa-levodopa was documented as administered daily at 8:00pm from 01/01/22 to 01/31/22. -The carbidopa-levodopa was documented as administered three times a day at 8:00am, 12:00pm, and 4:00pm from 01/01/22 to 01/31/22. Review of Resident #6's medication administration audit report for administration times for 01/24/22 to 01/31/22 revealed: -The carbidopa-levodopa 25-100mg 2 tablets scheduled at 8:00am was administered late for 5 out of 8 opportunities (on 01/25/22 at 10:38am, on 01/26/22 at 10:47am, on 01/27/22 at 9:48am, on 01/29/22 at 9:40am, and on 01/30/22 at 9:30am). -The carbidopa-levodopa 25-100mg 1 tablet scheduled at 8:00pm was administered late for 2 out of 8 opportunities (on 01/26/22 at 9:53pm and on 01/29/22 at 10:08pm). -The carbidopa-levodopa ER 25-100mg 1 tablet scheduled at 8:00pm was administered late for 2 out of 8 opportunities (on 01/26/22 at 9:53pm and on 01/29/22 at 10:08pm). Review of Resident #6's February 2022 eMAR	D 358		

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D 358	Continued From page 15 revealed: -There was an entry for carbidopa-levodopa ER 25-100mg one tablet daily scheduled at 8:00pm. -There was an entry for carbidopa-levodopa 25-100mg one tablet daily scheduled at 8:00pm. -There was an entry for carbidopa-levodopa 25-100mg two tablets three times a day scheduled at 8:00am, 12:00pm, and 4:00pm. -The carbidopa-levodopa ER was documented as administered daily at 8:00pm from 02/01/22 to 02/10/22. -The carbidopa-levodopa was documented as administered daily at 8:00pm from 02/01/22 to 02/10/22. -The carbidopa-levodopa was documented as administered three times a day at 8:00am, 12:00pm, and 4:00pm from 02/01/22 to 02/10/22. Review of Resident #6's medication administration audit report for administration times for 02/01/22 to 02/10/22 revealed: -The carbidopa-levodopa 25-100mg 2 tablets scheduled at 8:00am was administered late for 5 out of 10 opportunities (on 02/02/22 at 10:05am, on 02/03/22 at 10:10am, on 02/04/22 at 10:02, on 02/05/22 at 9:17am, and 02/06/22 at 10:12am). -The carbidopa-levodopa 25-100mg 2 tablets scheduled at 12:00pm was administered late for 2 out of 10 opportunities (on 02/04/22 at 1:37pm, and on 02/09/22 at 1:07pm). -The carbidopa-levodopa 25-100mg 1 tablet scheduled at 8:00pm was administered late for 5 out of 9 opportunities (on 02/01/22 at 11:02pm, 02/03/22 at 11:05pm, 02/04/22 at 11:35pm, 02/05/22 at 11:19pm, and 02/09/22 at 11:19pm). -The carbidopa-levodopa ER 25-100mg 1 tablet scheduled at 8:00pm was administered late for 5 out of 9 opportunities (on 02/01/22 at 11:02pm, 02/03/22 at 11:05pm, 02/04/22 at 11:35pm, 02/05/22 at 11:19pm, and 02/09/22 at 11:19pm).	D 358		

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D 358	Continued From page 16 Observation of Resident #6's medications on hand on 02/11/22 at 11:21am revealed: -There was one bubble pack of carbidopa/levodopa 25-100mg tablets with 10 tablets remaining dispensed on 01/11/22. -There was one bubble pack of carbidopa/levodopa 25-100mg tablets with 18 tablets remaining dispensed on 02/03/22. -There was one bubble pack of carbidopa/levodopa ER 25-100mg tablets with 4 tablets remaining dispensed on 12/29/21. Telephone interview with Resident #6's Primary Care Provider (PCP) on 02/11/22 at 11:45am revealed: -Resident #6 was prescribed carbidopa-levodopa to control the symptoms of Parkinson's disease. -Receiving doses of carbidopa-levodopa one hour before or one hour after the scheduled time was "reasonable". -Administering the carbidopa-levodopa two hours after the scheduled time was administering the doses "too close together" and should be "spaced apart" throughout the day. -When staff administered the carbidopa-levodopa "two hours late" she would expect staff to call her for a "give or hold" order and about spacing out future doses. Interview with a medication aide (MA) on 02/11/22 at 2:03pm revealed: -Staff who administered medications on the assisted living halls could get "behind" and administer the morning medications late for various reasons. -The MA staff had to assist the personal care aides with resident care needs which occurred during medication passes. -In emergency situations, the MA staff had to	D 358		

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assess residents with emergency situations and get the paperwork together to send residents out for medical care.
-Those types of situations could cause staff to administer medications "late."
-The MA staff who administered medications on the assisted living halls "always" was responsible to administer medications to all the assisted living residents on 100, 200, and 300 halls.
-If the MA staff was "behind" with the medication pass, they were supposed to "come tell somebody" they needed help.
-There was always extra staff available who were trained to administer medications on first and second shifts.

Interview with the Administrator on 02/11/22 at 3:30pm revealed:
-Resident #6 had not relayed any concerns to her about receiving the carbidopa-levodopa later that expected at times.
-The MAs knew if they got behind schedule during medication pass they "can always as for help" from one of the resident care coordinators' or another MA.

Refer to the facility's Medication Administration Policy dated 06/2020.

4. Review of Resident #3's current FL2 dated 12/09/21 revealed diagnoses included Alzheimer's disease, depression, and osteoarthritis.

a. Review of Resident #3's Primary Care Provider (PCP) orders dated 12/09/21 revealed there was an order for quetiapine (a medication used to treat depression) 25mg take one tablet twice daily.

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Review of Resident #3's PCP subsequent orders dated 01/03/22 revealed an order for quetiapine 25mg take one tablet every evening.

Review of Resident #3's PCP subsequent orders dated 02/07/22 revealed:
-An order for quetiapine 25mg one tablet daily in the evening at 6:00pm.
-An order for quetiapine 25mg one tablet twice daily at 8:00am and 9:00pm.

Review of Resident #3's December 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for quetiapine 25mg one tablet twice daily.
-Quetiapine was documented as administered at 8:00am from 12/17/21 through 12/31/21.
-Quetiapine was documented as administered at 8:00pm from 12/18/21 through 12/24/21.
-Quetiapine was documented as administered at 9:00pm from 12/25/21 through 13/31/21.

Review of Resident #3's January 2022 eMAR revealed:
-There was an entry for quetiapine 25mg one tablet twice daily.
-Quetiapine was documented as administered at 8:00am from 01/01/22 through 01/31/22.
-Quetiapine was documented as administered at 9:00pm from 01/01/22 through 01/31/22.
-There was an entry for quetiapine 25mg one tablet in the evening at 6:00pm.
-Quetiapine was documented as administered at 6:00pm from 01/05/22 through 01/31/22 except on 01/07/22 and 01/10/22 with no documentation why quetiapine was not administered, and should have been discontinued on 01/11/22.

Review of Resident #3's February 2022 eMAR

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revealed:
-There was an entry for quetiapine 25mg one tablet twice daily.
-Quetiapine was documented as administered at 8:00am from 02/01/22 through 02/10/22.
-Quetiapine was documented as administered at 9:00pm from 02/01/22 through 02/10/22.
-There was an entry for quetiapine 25mg one tablet in the evening at 6:00pm.
-Quetiapine was documented as administered at 6:00pm from 02/01/22 through 02/10/22 except on 02/03/22 with no documentation why quetiapine was not administered, and should have been discontinued on 01/11/22.

Observations of medications on hand for Resident #3 on 02/11/22 at 3:42pm revealed:
-There was no quetiapine 25mg tablets take one tablet every evening available for administration.
-There was a bubble pack containing quetiapine 25mg take one tablet twice daily available for administration.

Interview with a representative from the facility's contracted pharmacy on 02/11/22 at 4:30pm revealed:
-An order dated 01/11/22 was faxed to the pharmacy from the facility to discontinue Resident #3's quetiapine 25mg one tablet in the evening.
-Quetiapine 25mg one tablet twice daily was the only current active order for Resident #3's quetiapine.
-Quetiapine 25mg one tablet twice daily was last dispensed on 01/27/22 in the quantity of 60 tablets.

Telephone interview with Resident #3's PCP on 02/11/22 at 5:22pm revealed:
-She ordered quetiapine 25mg take one tablet daily in the evening for Resident #3.

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-She did not know she had subsequent orders for Resident #3's quetiapine 25mg take one tablet twice daily and take one tablet in the evening because she had only received one page of the FL2 when it was faxed to the office from the facility, and the quetiapine orders were on two different documents (FL2 and physician's order sheet).
-Resident #3 was supposed to be administered quetiapine 25mg once daily.

Interview with the Resident Care Coordinator (RCC) on 02/10/22 at 9:45am revealed she was responsible for entering or changing medication orders on the electronic Medication Administration Record (eMAR).

Interview with Resident #3 on 02/09/22 at 10:20am revealed she did not know what medications she took daily.

Interview with the Administrator on 02/10/22 at 4:30pm revealed:
-The Resident Care Coordinator (RCC) was responsible for medication cart audits but the RCC had not completed one since being hired due to staffing issues.
-She could not locate the order to discontinue Resident #3's quetiapine 25mg in the evening at 6:00pm.
-MA's were responsible for requesting refills on medications that were low in stock or missing.
-The residents ordered medications were supposed to be stocked on the medication cart and available for administration.

Review of the Medication and Treatment Availability Policy dated 12/2017 revealed the facility was responsible for obtaining newly ordered medication or refills for medications and

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treatment orders.

Refer to the facility's Medication Administration Policy dated 06/2020.

b. Review of Resident #3's Primary Care Providers (PCP) orders dated 12/09/21 revealed there was an order for celecoxib (a medication used to treat pain and inflammation in osteoarthritis) 200mg take 1 capsule every 12 hours as needed for pain.

Interview with Resident #3 on 02/09/22 at 10:20am revealed:
-Her knees hurt, and she was "always" in pain.
-She did not know if she had any medications available to take for pain.

Interview with a medication aide (MA) on 02/09/22 at 10:23am revealed she administered Resident #3's scheduled Tylenol (a medication used to treat mild pain) at 9:00am.

Review of Resident #3's December 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for celecoxib 200mg take one capsule every twelve hours as needed for pain.
-There was no documentation celecoxib was administered.

Review of Resident #3's January 2022 eMAR revealed:
-There was an entry for celecoxib 200mg take one capsule every twelve hours as needed for pain.
-There was no documentation celecoxib was administered.

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Review of Resident #3's February 2022 eMAR revealed:
-There was an entry for celecoxib 200mg take one capsule every twelve hours as needed for pain.
-There was no documentation celecoxib was administered.

Observations of medications on hand for Resident #3 on 02/11/22 at 3:42pm revealed there was no celecoxib available for administration.

Interview with a representative from the facility's contracted pharmacy on 02/11/22 at 4:30pm revealed:
-Resident #3's celecoxib 200mg capsules were dispensed once on 01/24/22 four capsules.
-The facility would have to place a refill request for Resident #3's celecoxib since it was ordered as needed to be dispensed but no request had been made by the facility.

Telephone interview with Resident #3's PCP on 02/11/22 at 5:22pm revealed:
-She had ordered celecoxib on 12/09/21 for Resident #3's pain and to decrease inflammation related to Resident #3's osteoarthritis.
-Resident #3 had experienced increased pain in her knees.
-Resident #3 could experience decreased mobility and increased pain from not receiving the ordered celecoxib.
-She expected facility staff to administer medications as ordered.

Interview with a medication aide (MA) on 02/11/22 at 3:50pm revealed:
-She did not know Resident #3's celecoxib was missing from the medication cart.

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-Sometimes medications were stored on the "overflow" medication cart but Resident #3's celecoxib was not on the "overflow" cart.

Interview with the Administrator on 02/10/22 at 4:30pm revealed:
-The Resident Care Coordinator (RCC) was responsible for medication cart audits but the RCC had not completed one since being hired due to staffing issues.
-MA's were responsible for requesting refills on medications that were low in stock or missing.
-The residents ordered medications were supposed to be stocked on the medication cart and available for administration.

Review of the Medication and Treatment Availability Policy dated 12/2017 revealed the facility was responsible for obtaining newly ordered medication or refills for medications and treatment orders.

Refer to the facility's Medication Administration Policy dated 06/2020.

c. Review of Resident #3's Primary Care Provider (PCP) orders dated 01/05/22 revealed an order for Ben Gay apply to hips, knees, and lower back topically as needed for pain four times a day.

Interview with Resident #3 on 02/09/22 at 10:20am revealed:
-Her knees hurt, and she was "always" in pain.
-She did not know if she had any medications available to take for pain.

Interview with a medication aide (MA) on 02/09/22 at 10:23am revealed she administered Resident #3's scheduled Tylenol (a medication used to treat mild pain) at 9:00am.

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D 358	Continued From page 24 Review of Resident #3's December 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Ben Gay apply to hips, knees, and lower back topically as needed for pain four times a day. -There was no documentation Ben Gay was administered. Review of Resident #3's January 2022 eMAR revealed: -There was an entry for Ben Gay apply to hips, knees, and lower back topically as needed for pain four times a day. -There was no documentation Ben Gay was administered. Review of Resident #3's February 2022 eMAR revealed: -There was an entry for Ben Gay apply to hips, knees, and lower back topically as needed for pain four times a day. -There was no documentation Ben Gay was administered. Observations of medications on hand for Resident #3 on 02/11/22 at 3:42pm revealed there was no Ben Gay available for administration. Interview with a representative from the facility's contracted pharmacy on 02/11/22 at 4:30pm revealed Resident #3's Ben Gay was last dispensed on 01/06/22 in the quantity of a 57gram tube. Interview with a medication aide (MA) on 02/11/22 at 3:50pm revealed: -She did not know why Resident #3's Ben Gay	D 358		

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was missing from the medication cart.
-Sometimes medications were stored on the "overflow" medication cart but Resident #3's Ben Gay was not on the "overflow" cart.

Telephone interview with the PCP on 02/11/22 at 5:22pm revealed:
-She had ordered Resident #3's Ben Gay ointment for knee, hip, and back pain on 01/05/22.
-Resident #3 had experienced increased pain in her knees.
-Resident #3 could experience decreased mobility and increased pain from not receiving the ordered Ben Gay ointment.
-She expected facility staff to administer medications as ordered.

Interview with the Administrator on 02/10/22 at 4:30pm revealed:
-A medication cart audit was recently completed (no date provided) by the facility's contracted pharmacy.
-MA's were responsible for requesting refills for medications that were low in stock or missing.
-The residents ordered medications were supposed to be stocked on the medication cart and available for administration.

Review of the Medication and Treatment Availability Policy dated 12/2017 revealed the facility was responsible for obtaining newly ordered medication or refills for medications and treatment orders.

Refer to the facility's Medication Administration Policy dated 06/2020.

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Review of the facility's Medication Administration Policy dated 06/2020 revealed:

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BROOKDALE FOREST CITY	493 PINEY RIDGE ROAD FOREST CITY, NC 28043

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D 358	Continued From page 26 -Medications and treatments should be administered within the parameters of the Physician/Health Care Professional orders. -Medication and/or treatment errors should be reported promptly. -Medications should be administered within one hour before or one hour after the prescribed frequency and time. _____ The facility failed to ensure medications were administered as ordered to 4 of 6 sampled residents, including Resident #1 who did not receive a rapid-acting insulin as ordered on multiple occasions resulting in hemoglobin A1C values increasing from 9.8% to 10.7% in a 3 month period of time (normal range is below 5.7%), putting the resident at risk of infection, diabetic retinopathy (a complication of diabetes that can lead to blindness), and kidney disease. This failure was detrimental to the health, safety, and welfare of Resident #1 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/10/22 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 28, 2022.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	D 367		

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D 367	Continued From page 27 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 1 of 7 residents sampled (#7) related to documentation of fingerstick blood sugar (FSBS) entries. The findings are: Review of Resident #7's current FL2 dated 12/16/21 revealed diagnoses included type 2 diabetes. Review of Resident #7's physician's orders dated 01/18/22 revealed there was an order for fingerstick blood sugar (FSBS) testing before every meal and at bedtime. Observation of Resident #7's FSBS test during the 12:00pm medication pass on 02/09/22 at 12:21pm revealed:	D 367		

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-The medication aide (MA) removed a black zippered hard case from the top drawer of the medication cart.
-There was a second black zippered soft case clearly labeled with another resident's name located in the same drawer where the MA removed the black zippered hard case.
-The black zippered case was not labeled with a resident name.
-Inside the black zippered case was a Brand A glucometer.
-The Brand A glucometer was not labeled with a resident name.

Interview with the same MA on 02/09/22 at 12:24pm revealed:
-The black zippered hard case with the Brand A glucometer belonged to Resident #7.
-Resident #7 had brought the case and glucometer from home.
-She did not know why it did not have Resident #7's name on the outside of the case or written on the glucometer inside.
-Resident #7 and one other resident were the only two residents on the medication cart with FSBS testing equipment.
-Resident #7 was the only resident to have a black zippered hard case and a Brand A glucometer.
-She never shared resident glucometers.

Review of Resident #7's glucometer memory consecutive results from 01/23/22 to 02 09/22 at 3:25pm revealed:
-There were 66 values in the glucometer memory dated 01/23/22 to 02/09/22.
-Of the 66 values in the glucometer memory dated 01/23/22 to 02/09/22, 8 values did not match the entries documented in Resident #6's electronic Medication Administration Record

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(eMAR).
-On 02/07/22 at 10:24am the glucometer value was 115, the eMAR documentation was 02/07/22 at 9:46am was 215.
-On 02/04/22 at 5:51pm the glucometer value was 166, the eMAR documentation was 02/04/22 at 5:54pm was 132
-On 02/04/22 at 1:22pm the glucometer value was 159, the eMAR documentation was 02/04/22 at 12:32pm was 152.
-On 02/08/22 at 11:41pm the glucometer value was 224, the eMAR documentation was 02/04/22 at 12:29am was 115.
-On 01/31/22 at 10:38pm the glucometer value was 317, the eMAR documentation was 01/31/22 at 10:31pm was 316.
-On 01/28/22 at 11:32pm the glucometer value was 198, there was no eMAR documentation.
-On 01/28/22 at 8:39am the glucometer value was 125, the eMAR documentation was 01/28/22 at 10:01am was 127.
-On 01/23/22 at 10:32pm the glucometer value was 338, the eMAR documentation was 01/23/22 at 10:37pm was 330.

Review of Resident #7's January 2022 eMAR from 01/23/22 to 01/31/22 revealed:
-On 01/24/22 at 5:53pm there was a 323 documented, but no corresponding value in the glucometer history.
-On 01/26/22 at 8:55pm there was a 215 documented, but no corresponding value in the glucometer history.
-On 01/29/22 at 9:12pm there was a 167 documented, but no corresponding value in the glucometer history.

Review of Resident #7's February 2022 eMAR from 02/01/22 to 02/09/22 revealed:
-On 02/04/22 at 12:29am there was a 115

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D 367	Continued From page 30 documented, but no corresponding value in the glucometer history. -On 02/05/22 at 6:31pm there was a 172 documented, but no corresponding value in the glucometer history. -On 02/07/22 at 1:53pm there was a 174 documented, but no corresponding value in the glucometer history. Interview with the RCC on 02/11/22 at 2:03pm revealed staff should check the glucometer result just prior to documenting the result in the eMAR to ensure accuracy.	D 367		
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, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration and staff qualifications. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 4 of 6 sampled residents (#1, #2, #3, and #6) related to a	D912		

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D912	Continued From page 31 rapid-acting insulin to control high blood sugar levels (#1), a medication used to treat tremors, stiffness, and difficulty with movement (#6), medications used to treat fluid retention and anxiety (#2), and medications used to treat depression and pain (#3). [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 2. Based on interviews, and record reviews the facility failed to ensure 2 of 3 sampled staff (A and B) who administered medications had completed the 5, 10, and 15 hour medication administration training course or had documentation of the medication aide verification form (A), and staff with no documentation for verification of passing the medication aide exam prior to administering medications (B).[Refer to Tag 935, G.S. 131D-4.5B(b) Adult Care Home Medication Aides Training and Competency Evaluation Requirements (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following:	D935		

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D935	Continued From page 32 a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews the facility failed to ensure 2 of 3 sampled staff (A and B) who administered medications had completed the 5, 10, and 15 hour medication administration training course or had documentation of the medication aide verification form (A), and staff with no documentation for verification of passing the medication aide exam prior to administering medications (B).	D935		

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D935	Continued From page 33 The findings are: 1. Review of Staff A's personnel record revealed: -Staff A's hire date was documented as 10/22/21. -Staff A passed the medication aide (MA) exam on 07/25/17. -There was documentation Staff A completed the 5-hour medication administration training course on 11/16/21. -There was no documentation Staff A completed the 10-hour or 15-hour medication administration training course. -There was no documentation of medication aide employment verification in Staff A's personnel record. Review of a resident's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry to check blood sugars before meals and at bedtime. -There was an entry for Novolog (a medication used to lower blood sugar levels) 100 units, 5 units every 4 hours as needed if the blood sugar reading was greater than 200. -Staff A documented administering 13 doses of Novolog out of 16 opportunities when the blood sugar reading was greater than 200. -There was documentation Staff A administered Novolog with a blood sugar reading less than 200 on 12/13/21 with a reading of 55 and again on 12/15/21 with a reading of 50. Review of a resident's January 2022 eMAR revealed: -There was an entry to check blood sugars before meals and at bedtime. -There was an entry for Novolog 100 units, 5 units every 4 hours as needed if the blood sugar reading was greater than 200.	D935		

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-Staff A documented administering 11 doses of Novolog out of 14 opportunities when the blood sugar reading was greater than 200.

Interview with Staff A, medication aide (MA) on 02/10/22 at 12:20pm revealed:
-She completed diabetic care training in November 2021 after she was hired in October 2021.
-She was a MA since 2017.

Interview with the Administrator on 02/11/22 at 2:30pm revealed:
-Staff A was hired on 10/22/21 and completed the 5-hour medication administration training including diabetic training on 11/16/21.
-Staff A did not complete the 10-hour or 15-hour medication administration training.
-Staff A passed the medication administration exam on 07/25/17 and she did not know Staff A was required to have the 15-hour medication administration documentation or an employment verification form.
-She thought Staff A had 6 months to complete the MA training.

2. Review of Staff B's personnel record revealed:
-Staff B's hire date was documented as 02/17/21.
-There was documentation Staff B completed the 15-hour medication administration training course on 08/19/21.
-Staff B completed the Medication Clinical Skills Competency Evaluation on 10/12/21.
-There was no documentation Staff B passed the written medication aide (MA) examination.

Review of a resident's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry to check blood sugars before

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meals and at bedtime.
-There was an entry for Novolog 100 units, 5 units every four hours as needed if the blood sugar reading was greater than 200.
-Staff B documented administering 7 doses of Novolog out of 8 opportunities when the blood sugar reading was greater than 200.
-There was documentation Staff B administered Novolog on 12/23/21 with a blood sugar reading less than 200.

Review of a resident's January 2022 eMAR revealed:
-There was an entry to check blood sugars before meals and at bedtime.
-There was an entry for Novolog 100 units, 5 units every 4 hours as needed if the blood sugar reading was greater than 200.
-Staff B documented administering 9 doses of Novolog out of 18 opportunities when the blood sugar reading was greater than 200.
-There was documentation Staff B administered Novolog on 01/30/22 with a blood sugar reading less than 200.

Review of a resident's February 2022 eMAR revealed:
-There was an entry to check blood sugars before meals and at bedtime.
-There was an entry for Novolog 100 units, 5 units every 4 hours as needed if the blood sugar reading was greater than 200.
-Staff B documented administering one dose of Novolog out of 2 opportunities when the blood sugar reading was greater than 200.

Interview with the Administrator on 02/11/22 at 2:30pm revealed:
-Staff B completed the 15-hour MA training on 08/19/21 and the Medication Clinical Skills

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D935	Continued From page 36 Evaluation was completed on 10/12/21. -She did not know Staff B had to successfully pass the written state exam within 60 days of hire. -Staff B notified her a "couple days" prior he was unsuccessful scheduling an appointment to take the MA examination. The facility failed to ensure 2 of 3 sampled staff (A and B), who were administering medications to residents in the facility completed the 5, 10, or 15-hour medication administration training course or had documentation of employment as a medication aide (MA) in the previous 24 months (staff A), and successfully passed the MA examination within 60 days of hire (staff B). The facility's failure to ensure MA's met training requirements prior to the administration of medications resulted in insulin errors which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/11/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 28, 2022.	D935		