STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 000	Initial Comments The Adult Care Licensure Section and Mecklenburg County Department of Social Services conducted an annual survey on October 19 and 20, 2022.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision according to the needs of 1 of 5 sampled residents with a history of repeated falls, emergency room (ER) visits and injuries including bone fractures and a head laceration. The findings are: Review of the facility's Falls Management Policy dated 10/2013 with current revisions dated 02/2022 revealed: -A fall referred to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury. -A post fall evaluation was completed after a resident fell, individualized interventions were considered, and the evaluation was part of the resident record.	D 270		

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D 270	Continued From page 1 -Falls, injuries, resident response and interventions taken were documented in the resident record. -The service plan (care plan) was reviewed for potential fall interventions and updated as necessary. -Falls were reviewed at the next stand-up meeting. -Resident falls were discussed at the next collaborative care review meeting Review of Resident #4's current FL-2 dated 12/15/21 revealed diagnoses included chronic gout, hypertension, anxiety, hyperlipidemia and aphasia. Review of Resident #4's physician's order dated 09/15/21 revealed an order for a concave mattress on a hospital bed. Review of Resident #4's current care plan dated 09/22/22 revealed: -In addition to the facility's universal fall precautions for all residents, Resident #4 had a wheelchair with a right arm trough and bilateral assist rails on his bed. -A fall mat and concave mattress were implemented in September 2021. -He had 19 falls between April and December 2021. -During 2022 the following falls and interventions were documented: 01/11/22 monitor frequently and ensure comfortable position especially during overnight hours; 04/17/22 monitor frequently especially when he was agitated; 04/21/22 monitor frequently; 05/01/22, 05/03/22 and 05/29/22 antibiotic therapy for urinary tract infection; and 06/20/22, 07/05/22, 07/07/22, 07/16/22, 07/23/22, 08/28/22 and 09/09/22 there were no interventions implemented.	D 270		

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-He was at times confused and not oriented to place and time.
-He required two staff and a mechanical lift for all transfers.
-He was non-ambulatory and bedbound.
-He was totally dependent on staff for toileting, bathing and dressing.

Review of Resident #4's electronic progress note dated 04/17/22 revealed:
-He fell trying to leave the facility.
-He did not have any injuries.

Review of Resident #4's accident and incident report dated 04/17/22 revealed:
-He had an unwitnessed fall at 3:15pm in his room with no injury.
-Vital signs were documented.
-Hospice, the family member and facility nurse were notified.

Review of Resident #4's electronic progress note dated 04/21/22 revealed:
-He fell and told staff he was trying to get out of bed to take a shower.
-A message was left for the family member.
-Hospice and the Health and Wellness Director (HWD) were notified.
-There was documentation staff would continue to monitor and report changes.

Review of Resident #4's accident and incident report dated 04/21/22 revealed:
-He had an unwitnessed fall at 8:45am in his room with no injury.
-Vital signs were documented.
-Hospice, the family member and facility nurse were notified.

Review of Resident #4's electronic progress note

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dated 05/01/22 revealed:
-He fell around 2:30pm.
-He told staff he wanted to get his pants.
-Hospice and the family member were notified.

Review of Resident #4's accident and incident report dated 05/01/22 revealed:
-He had an unwitnessed fall at 2:30pm in his room with no injury.
-Vital signs were documented.
-Hospice, the family member and facility nurse were notified.

Review of Resident #4's electronic progress note dated 05/03/22 revealed:
-He was found on the floor around 6:00am and told staff he liked being on the floor.
-He had a small skin tear on his left wrist.
-He was instructed to call staff for assistance and repositioning.
-His family member was notified.

Review of Resident #4's accident and incident report dated 05/03/22 revealed:
-He had an unwitnessed fall at 1:00am in his room with no injury.
-Vital signs were documented.
-Hospice, the family member and facility nurse were notified.

Review of Resident #4's electronic progress note dated 05/04/22 revealed:
-He was found on the floor after dinner around 6:15pm.
-He was upset but calmed down and was assisted back to bed.
-There was documentation staff would continue to monitor and report any changes.

Review of Resident #4's electronic progress note

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D 270	Continued From page 4 dated 05/29/22 revealed: -He was found on the floor in his room when the personal care aide (PCA) delivered lunch beverages. -Staff assisted him back to bed and he did not have any injuries. -Hospice, the family member and Resident Care Coordinator (RCC) were notified. -There was documentation staff would continue to monitor and report any changes. Review of Resident #4's accident and incident report dated 05/29/22 revealed: -He had an unwitnessed fall at 1:00pm in his room without injury. -Vital signs were documented. -Hospice, the family member and facility nurse were notified. Review of Resident #4's electronic progress note dated 06/03/22 revealed: -He was found on the floor at the start of first shift and refused to get back into his bed. -He told staff his back hurt and to leave him alone. -He was given "something" for pain. -There was no documentation on how he got onto the floor, actions taken after the pain medication or supervision. Review of Resident #4's hospice nurse visit note dated 06/13/22 revealed staff reported he got up from his bed and made it to his closet before being found by staff last night. Review of Resident #4's electronic progress notes revealed there was no entry documenting intervention or supervision dated 06/12/22 or 06/13/22.	D 270		

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D 270	Continued From page 5 Review of Resident #4's electronic progress note dated 06/16/22 revealed: -He rolled over from the bed onto the floor mat and told staff he wanted to walk to his car. -He did not have any injuries. -There was documentation staff would continue to monitor. Review of Resident #4's electronic progress note dated 06/26/22 revealed: -He fell around 1:20pm and had a skin tear on his right elbow. -He told staff he had to get out of the facility. -Hospice and the family member were notified. -There was no documentation of fall prevention interventions or increased supervision. Review of Resident #4's accident and incident report dated 06/26/22 revealed: -He had an unwitnessed fall at 1:20pm in his room with a skin tear on his right elbow. -First aid was applied, and vital signs were documented. -Hospice, the family member and facility nurse were notified. Review of Resident #4's electronic progress note dated 07/05/22 revealed: -He was found on the floor at 12:00pm, he told staff he was going to take a shower. -Hospice, the family member and the facility nurse were notified. -There was no documentation of fall prevention interventions or increased supervision. Review of Resident #4's accident and incident report dated 07/05/22 revealed: -He had an unwitnessed fall at 12:00pm in his room with no injury. -Vital signs were documented.	D 270		

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D 270	Continued From page 6 -Hospice, the family member and facility nurse were notified. Review of Resident #4's electronic progress note dated 07/05/22 revealed: -He was found lying beside his bed at 5:40pm, he told staff he lost his balance trying to go to the bathroom. -Hospice, the family member and Resident Care Coordinator (RCC) were notified. -There was no documentation of fall prevention interventions or increased supervision. Review of Resident #4's accident and incident report dated 07/05/22 revealed: -He had an unwitnessed fall at 5:40pm in his room with no injury. -Vital signs were documented. -Hospice, the family member and facility nurse were notified. Review of Resident #4's electronic progress note dated 07/07/22 revealed: -He fell around 9:15pm and did not have any apparent injuries. -There was no documentation of fall prevention interventions or increased supervision. Review of Resident #4's accident and incident report dated 07/07/22 revealed: -He had an unwitnessed fall at 9:20pm in his room with no injury. -Vital signs were documented. -Hospice, the family member and facility nurse were notified. Review of Resident #4's electronic progress note dated 07/16/22 revealed: -He fell at 6:30pm, he told staff he was looking for his car and did not have any apparent injuries.	D 270		

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-Hospice, the family member and Resident Care Coordinator (RCC) were notified.
-There was no documentation of fall prevention interventions or increased supervision.

Review of Resident #4's accident and incident report dated 07/16/22 revealed:
-He had an unwitnessed fall at 6:30pm in his room with no injury.
-Vital signs were documented.
-Hospice, the family member and facility nurse were notified.

Review of Resident #4's electronic progress notes dated 07/23/22 revealed:
-He was found on the floor in his room beside his bed with his left arm twisted behind his body between him and the bed.
-The hospice nurse was called and came to the facility.
-He was sent to the emergency room (ER) for further evaluation.
-He returned to the facility around dinner time.
-There was no documentation of fall prevention interventions or increased supervision.

Review of Resident #4's accident and incident report dated 07/23/22 revealed:
-He had an unwitnessed fall at 9:20pm in his room with a fracture of his left arm/shoulder.
-Vital signs were documented and emergency medical services (EMS) was called.
-Hospice, the family member and facility nurse were notified.

Review of Resident #4's emergency room (ER) discharge instructions dated 07/23/22 revealed he was evaluated for a fall and diagnosed with a closed fracture of the proximal end of the left humerus (shoulder).

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D 270	Continued From page 8 Review of Resident #4's electronic progress note dated 08/16/22 revealed: -The resident fell at 11:00pm and did not have any injuries. -Hospice, the family member and Resident Care Coordinator (RCC) were notified. -There was no documentation of fall prevention interventions or increased supervision. Review of Resident #4's accident and incident report dated 08/16/22 revealed: -He had an unwitnessed fall at 11:00pm in his room with no injury. -Vital signs were documented. -Hospice, the family member and facility nurse were notified. Review of Resident #4's electronic progress notes revealed there was no entry for a fall on 08/28/22. Review of Resident #4's accident and incident report dated 08/28/22 revealed: -He had an unwitnessed fall at 2:40pm in his room with no injury. -Vital signs were documented. -Hospice, the family member and facility nurse were notified. Review of Resident #4's electronic progress note dated 09/09/22 revealed: -He was found on the fall mat next to his bed without injury. -He told staff he was trying to find a ride to the airport. -Hospice, the family member and Resident Care Coordinator (RCC) were notified. -There was no documentation of fall prevention interventions or increased supervision.	D 270		

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D 270	Continued From page 9 Review of Resident #4's accident and incident report dated 09/09/22 revealed: -He had an unwitnessed fall at 8:30pm in his room with no injury. -Hospice, the family member and facility nurse were notified. Review of Resident #4's electronic progress notes dated 09/13/22 and 09/20/22 revealed the resident continued to "throw himself on the floor." Review of Resident #4's electronic progress note dated 09/26/22 revealed: -At the start of the shift, the resident was sitting in his recliner. -After dinner, a personal care aide (PCA) found him laying on the floor in front of his recliner. -He was assisted to his bed. -When the medication aide (MA) went to administer medications, he was attempting to get out of his bed. -Hospice and the family member were notified. -There was no documentation of fall prevention interventions or increased supervision. Review of Resident #4's hospice nurse visit note dated 09/29/22 revealed he had a skin tear on his right elbow from a recent fall. Review of Resident #4's electronic progress note dated 10/15/22 revealed: -He fell because he was looking for his house keys and wanted to leave the facility. -He was not injured and an as needed medication was administered for agitation. -Hospice and his family member were notified. -There was no documentation of fall prevention interventions or increased supervision.	D 270		

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Review of Resident #4's accident and incident report dated 10/15/22 revealed:
-He had an unwitnessed fall at 10:15pm in his room with no injury.
-Vital signs were documented.
-Hospice, the family member and facility nurse were notified.

Review of Resident #4's electronic progress note dated 10/20/22 revealed:
-He fell around 5:15am and had a deep wound with "much" bleeding below his left eye.
-Hospice was contacted and the hospice nurse called EMS.

Review of Resident #4's accident and incident report dated 10/20/22 revealed:
-He had an unwitnessed fall at 5:15am in his room with a bruise and laceration to his face/head.
-First aid was applied, and vital signs were documented.
-Hospice, the family member and facility nurse were notified.

Review of Resident #4's ER discharge instructions dated 10/20/22 revealed he was seen and evaluated for a fall and diagnosed with an abrasion and facial laceration repaired with medical glue.

Interview with a personal care aide (PCA) on 10/20/22 at 8:00am revealed:
-Resident #4 fell before her shift started on 10/20/22.
-He fell a lot and she did not know how he had the strength to try and get out of his bed.
-For one day after a fall, staff checked on him every 20-30 minutes.
-The checks were not documented.

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D 270	Continued From page 11 Interview with a medication aide (MA) on 10/20/22 at 7:52am revealed: -The outgoing third shift staff told her Resident #4 fell that morning and hit his head. -She did not know what time he fell. -The hospice nurse was at the facility and said to send him to the emergency room (ER) because of how deep the gash on his head was. -He had a habit of "throwing himself" out of his bed. -He would throw his legs over the edge of the bed and try to stand. -He was paralyzed on one side, unable to walk and bedbound. -He frequently said he was trying to get to his car because he had someplace to go. -When he got like that, he was determined to get up. -Staff did not get Resident #4 up out of the bed because he was bedbound. Observation of Resident #4 on 10/20/22 at 3:24pm revealed: -He was transferred to his bed from the ambulance stretcher by the paramedics. -There was swelling that was deep red in color around his left eye. -There was a closed wound (no visible sutures) approximately one inch in length at the center of the swollen area. -A PCA came into the room and lowered his bed and pulled the fall mat out. -After the resident mentioned reaching for his call string, she placed the string around the assist rail on his bed. Interview with Resident #4 on 10/20/22 at 3:24pm revealed: -He was trying to get to the call string that hung	D 270		

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on the wall behind his bed.
-He fell and hit his head on a bolt on the bottom frame of his bed.

Interview with a second PCA on 10/20/22 at 3:25pm revealed:
-She checked on Resident #4 every two hours.
-She had not been instructed to check him more frequently.
-He was able to use the call string and called for assistance regularly.
-When she was working, he called every hour.

Second interview with the MA on 10/20/22 at 11:20am revealed:
-There were no increased safety checks on Resident #4 after a fall.
-Staff did not document checks, they just knew when to go and check on Resident #4.
-They had tried getting him up to sit in a high back wheelchair, but he slid out of it.
-They had also tried using wedge pillows under the mattress to keep him from rolling out of the bed, but he managed to get over the pillows.

Interview with the hospice nurse on 10/20/22 at 11:28am revealed:
-Resident #4 started on hospice services on 07/05/21 and she had picked up residents at the facility, including Resident #4, starting a few months ago.
-She did not know when the fall mat was implemented for him, it was in place when she started.
-He would get confused, forget he did not have the ability to walk, try to get up and go places and then fall.
-He did not have the strength to sit up in a chair, he would slide out.
-He fell and fractured his arm before she started

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but she had seen him with the arm sling.
-She did not know if there had been discussion on moving his room closer to common areas.
-Staff reported that his falls were unwitnessed, and he would tell staff he was looking for his car keys.
-She did not see him this morning before he went to the ER, that would have been the on-call hospice nurse.

Telephone interview with the on-call hospice nurse on 10/20/22 at 3:36pm revealed:
-She got a message at 5:39am on 10/20/22 that Resident #4 fell and was bleeding profusely.
-She tried calling the facility to tell them to send him to the ER but there was no answer.
-She drove to the facility and when she arrived the bleeding had stopped because the MA had applied pressure to the wound.
-The wound was still open - the edges did not come together, and his left eye was swollen shut.
-He was lying on his back on the fall mat.

Interview with the Resident Care Coordinator (RCC) on 10/20/22 at 4:21pm revealed:
-Resident #4 was able to use his call string.
-He was not able to stand or sit for long periods and refused to get out of bed frequently.
-The fall mat was implemented on 09/03/21 which was documented on his previous care plan dated March 2022.
-All his falls were unwitnessed.
-He would tell staff that he threw himself on the floor.
-She and staff had repeatedly tried to encourage Resident #4 to come out of his room for meals and activities.
-The Activities Director had done one on one activities with him.
-She was pretty sure there had been interventions

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D 270	Continued From page 14 implemented after June 2022. -She could not remember what interventions had been implemented and was not sure if the interventions had been documented. -Staff increased the frequency checks on Resident #4 to every hour until his behavior returned to baseline. -The hourly checks were not documented. -Abnormal behavior would occur with symptoms of a urinary tract infection and return to baseline after antibiotics. Interview with the Health and Wellness Director (HWD) on 10/20/22 at 4:21pm revealed: -Resident #4 was on hospice and it was preferred for hospice to manage illness and/or injury if possible. -Residents were checked every two hours, sometimes more often with medication administration. -She was new to the HWD position (one month) and was working with the RCC to develop a plan for supervision needs of Resident #4. Interview with the Administrator on 10/20/22 at 2:00pm revealed: -Residents were routinely checked every two hours. -She was not sure what more could have been done for Resident #4. -Physical and occupational therapies were not an option while receiving hospice services. -He and his family member have refused him being brought out to the common areas for increased monitoring. -He had high anxiety and preferred to remain in his room. -Increased checks had not been implemented for him prior to 10/20/22.	D 270		

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D 270	Continued From page 15 The facility's failure to provide supervision for Resident #4 resulted in 20 unwitnessed falls from 04/17/22 through 10/20/22, two emergency room (ER) visits, a left arm/shoulder fracture and a head laceration requiring medical glue for wound closure. This failure put the resident at substantial risk for serious physical injury and death and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/20/22. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 19, 2022.	D 270		
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 residents (#6, #7, #8) observed during the medication pass including errors with topical medications for redness and fungal infections (#6); a topical medication for pain and inflammation (#7); and	D 358		

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medications for seasonal allergies, constipation, and acid reflux (#8).

The findings are:

1. The medication error rate was 23% as evidenced by the observation of 6 errors out of 26 opportunities during the 2:00pm medication pass on 10/19/22 and the 8:00am / 9:00am medication pass on 10/20/22.

a. Review of Resident #6's current FL-2 dated 09/11/22 revealed:
-Diagnoses included dementia, hypothyroidism, history of stroke, and blindness secondary to macular degeneration.
-There was an order for Desitin Paste 40% apply to groin, buttocks topically 3 times a day, mix with Nystatin Powder. (Desitin is a skin barrier cream used to treat and prevent redness and irritation. Nystatin is used to treat fungal infections of the skin.)
-There was an order for Nystatin Powder apply topically to groin, buttocks 3 times a day, mix with Desitin.

Review of Resident #6's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Desitin Paste 40% apply to groin, buttocks topically 3 times a day for rash/redness, mix with Nystatin Powder scheduled for 8:00am, 2:00pm, and 8:00pm.
-There was an entry for Nystatin Powder apply to groin, buttocks topically 3 times a day for rash, mix with Desitin Paste scheduled for 8:00am, 2:00pm, and 8:00pm.
-The entries for Desitin Paste and Nystatin Powder were both documented as administered from 10/01/22 through on 10/19/22.

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D 358	Continued From page 17 Observation of the 2:00pm medication pass on 10/19/22 revealed: -Resident #6 was in the bathroom receiving assistance with toileting by a personal care aide (PCA). -The PCA and the medication aide (MA) assisted the resident from the toilet to a standing position. -The resident's buttocks were reddened with skin intact. -The MA applied Desitin Paste 40% to the resident's buttocks at 2:07pm. -The MA did not mix any Nystatin Powder with the Desitin Paste prior to applying the Desitin Paste to the resident's buttocks. -The MA did not attempt or offer to apply any Nystatin Powder to the resident's buttocks. -The MA did not attempt or offer to apply any Desitin Paste or Nystatin Powder to the resident's groin. -The resident's groin area was not visible due to the resident standing in a crouched over position. Observation of Resident #6's medications on hand on 10/19/22 at 4:31pm revealed: -There was a supply of Desitin Paste 40% dispensed on 09/14/22 with instructions to mix with Nystatin Powder and apply to groin/buttock 3 times a day. -There was a supply of Nystatin Powder dispensed on 04/22/22 with instructions to apply to perineal area twice a day, mix with Desitin Paste. Interview with the MA on 10/19/22 at 3:05pm revealed: -She usually applied Desitin Paste and Nystatin Powder to the resident's buttocks during the morning medication pass.	D 358		

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D 358	Continued From page 18 -She only applied the Desitin Paste to the resident's buttocks during the 2:00pm medication pass because the using the Nystatin Powder with the Desitin Paste got "cakey" and stuck to the resident's skin. -The resident's groin did not have a rash so she did not apply Desitin or Nystatin to the resident's groin. -She was unsure when she last saw the resident's groin area. Observation of Resident #6 on 10/20/22 at 4:11pm revealed: -There was redness at her groin area bilaterally. -There were no open areas or sores. Interview with Resident #6 on 10/20/22 at 4:11pm revealed: -She could not say how long she had the redness on her groin. -The burning was a "terrible thing" and caused her discomfort. -The burning was improving. Interview with a PCA on 10/20/22 at 4:11pm revealed: -She did not know how long Resident #6 had the redness on her groin. -It had been ongoing for a while (she could not specify in weeks or months). -The redness was no worse or better than it had been all along. Interview with the Health and Wellness Director (HWD) on 10/19/22 at 4:41pm revealed: -The MAs should follow the orders on the MARs. -The MAs should put Resident #6's Desitin Paste and Nystatin Powder in a plastic cup and mixing it and then applying it to Resident #6's buttocks and groin.	D 358		

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-The resident had a history of redness and rashes and needed both medications to be applied as ordered on a scheduled basis.

Telephone interview with Resident #6's primary care provider (PCP) on 10/20/22 at 4:19pm revealed:
-Resident #6 had a history of redness and rashes on her buttocks/groin area.
-The Nystatin Powder was ordered to be mixed with the Desitin Paste in case there was a fungal component to the resident's skin rashes.
-Not mixing the Nystatin Powder with the Desitin Paste and applying to the resident's buttocks and groin area could cause the rash not to heal.

b. Review of Resident #7's current FL-2 dated 09/30/22 revealed:
-Diagnoses included dementia and generalized muscle weakness.
-There was an order for Voltaren Gel 1% apply 2 grams 3 times a day. (Voltaren Gel is a topical medication used to treat pain and inflammation.)
-The order did not specify where the Voltaren Gel should be applied.

Review of Resident #7's FL-2 physician's verification form dated 10/19/22 revealed verification to apply the Voltaren Gel 1% to both knees topically 3 times a day.

Review of Resident #7's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Voltaren Gel 1% apply to both knees topically 3 times a day for pain.
-Voltaren Gel was scheduled for administration at 9:00am, 2:00pm, and 9:00pm.

Observation of the 2:00pm medication pass on

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D 358	Continued From page 20 10/19/22 revealed: -The medication aide (MA) opened Resident #7's tube of Voltaren Gel 1% and squeezed a pea-sized amount and applied it with a gloved hand to the resident's right knee at 2:18pm. -The resident refused application of the Voltaren Gel to the left knee. -The MA did not use a measuring device to measure a 2gm dose. Observation of Resident #7's medications on hand on 10/19/22 at 2:45pm revealed: -There was a supply of Voltaren Gel 1% dispensed on 08/30/22 with instructions to apply 2gm topically to right knee 3 times a day. -There was a flat plastic dosing card in the bag with the Voltaren Gel that was marked for a 2gm dose and a 4gm dose. Interview with the MA on 10/19/22 at 2:40pm revealed: -She usually administered a pea-sized amount of Voltaren Gel to the front and back of Resident #7's knee. -She had not noticed the instructions on the label to apply 2gm. -She had not noticed there was a plastic dosing card in the bag with the Voltaren Gel for measuring the medication. Interview with Resident #7 on 10/20/22 at 11:17am revealed: -Both of his knees hurt and usually got Voltaren Gel applied to both knees. -His left knee had just recently started hurting. -The Voltaren Gel helped with his pain. Interview with the Resident Care Coordinator (RCC) on 10/19/22 at 4:41pm revealed: -When she wrote the information on the FL-2	D 358		

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verification form for Resident #7's Voltaren Gel, she inadvertently left off the 2gm dose as ordered on the FL-2.
-The 2gm dose did not print on the eMAR because it was left off of the verification order form.
-The MA should have notified her or the Health and Wellness Director (HWD) that the eMAR and the medication label did not match.
-The MAs should use the plastic dosing card to measure the Voltaren Gel.

Telephone interview with Resident #7's primary care provider (PCP) on 10/20/22 at 4:19pm revealed:
-The MAs should follow the order and measure the correct dosage of Voltaren Gel to Resident #7's knees.
-Not measuring the correct dosage may cause the medication to be less effective for pain.

c. Review of Resident #8's current FL-2 dated 11/28/21 revealed:
-Diagnoses included gastroesophageal reflux disease, acute kidney failure, primary adrenocortical insufficiency, hypertension, atrial fibrillation, and hyperlipidemia.
-There was an order for Flonase 50mcg Nasal Spray use 1 spray in both nostrils twice a day. (Flonase is used to treat symptoms of seasonal allergies.)

Review of Resident #8's physician's order sheet dated 09/11/22 revealed an order for Flonase 50mcg Nasal Spray use 1 spray in alternating nostrils twice a day.

Review of Resident #8's October 2022 electronic medication administration record (eMAR) revealed:

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-There was an entry for Flonase 50mcg 1 spray alternating nostrils two times a day for allergies.
-Flonase was scheduled for administration at 8:00am and 8:00pm.
-There was no documentation to indicate which nostril the Flonase was being administered.

Observation of the 8:00am medication pass on 10/20/22 revealed:
-The MA administered 2 sprays of Flonase into both of Resident #8's nostrils at 8:14am.
-The MA administered 2 sprays instead of 1 spray and she administered in both nostrils instead of alternating nostrils.

Observation of Resident #8's medications on hand on 10/20/22 at 10:30am revealed:
-There was a bottle of Flonase Nasal Spray dispensed on 09/01/22.
-The instructions were to administer 1 spray in each nostril twice a day.

Interview with the MA on 10/20/22 at 10:32am revealed:
-Resident #8 always had a runny nose.
-She sometimes administered 2 sprays of Flonase in each nostril if she did not hear the first spray come out.
-She had not noticed the instructions on the eMAR and the medication label did not match.

Interview with Resident #8 on 10/20/22 at 9:54am revealed:
-She did not remember if she received any nasal spray with her medications.
-She did not complain of any allergy symptoms.

Interview with the Health and Wellness Director (HWD) on 10/20/22 at 10:52am revealed:
-The MAs should administer medications as

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ordered.
-If the eMAR and the medication label did not match, the MAs should notify her or the Resident Care Coordinator (RCC).
-If the order was for 1 spray, the MA should not administer 2 sprays.
-In order to administer alternating nostrils, the MAs should document which nostril on the eMAR.

Telephone interview with Resident #8's primary care provider (PCP) on 10/20/22 at 4:19pm revealed:
-The MAs should administer the Flonase as ordered.
-She was unsure why the order was written for alternating nostrils; Flonase was usually administered in both nostrils.
-She may revise the order.
-The MA should have administered 1 spray instead of 2 sprays.
-She was not concerned about any side effects from getting 2 sprays instead of 1 spray.

d. Review of Resident #8's physician's order dated 01/10/22 revealed an order for Miralax take 17 grams (g) once daily. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the inside of the cap on the bottle has a marking for 17g that should be used to measure the dosage at the top of the white section of the inner cap.)

Review of Resident #8's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax give 17g by mouth one time a day for constipation.
-Miralax was scheduled for administration at 8:00am.

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D 358	Continued From page 24 Observation of the 8:00am medication pass on 10/20/22 revealed: -There was a white section lining the inside of the purple cap on the Miralax bottle. -There was "17g" imprinted near the top of the white section with an arrow pointing up to indicate the measurement for 17g was at the top of the white section inside the cap. -The medication aide (MA) poured the Miralax powder halfway below the marking for the 17g dose. -The MA did not measure the Miralax correctly and the full dosage was not mixed in the 5-ounce cup of water. -The MA mixed the Miralax powder in water and gave it to Resident #8 to take with her oral medications at 8:14am. -The resident drank all of the water with Miralax but a full 17g dosage was not prepared and administered to the resident. Observation of Resident #8's medications on hand on 10/20/22 at 10:30am revealed: -There was a bottle of Miralax dispensed on 09/15/22. -The instructions were to mix 1 capful (17g) with 4 to 8 ounces of water and drink once daily. -The inner white lining of the cap of the Miralax bottle had a marking for 17g with an arrow pointing top of the white section of the cap. Interview with the MA on 10/20/22 at 10:32am revealed: -She usually measured Resident #8's Miralax powder to the groove about halfway of the white lining inside the cap. -She had not noticed the marking for 17g pointing to the top of the inner white lining of the cap. -He was not aware of Resident #8 having any current issues with constipation.	D 358		

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D 358	Continued From page 25 Interview with Resident #8 on 10/20/22 at 9:54am revealed: -She was unsure if she took Miralax. -She denied any current issues with constipation or diarrhea. Interview with the Health and Wellness Director (HWD) on 10/20/22 at 10:52am revealed: -The MAs should measure Miralax using the marking of 17g at the top of the inner white cap. -Resident #8 had no current issues with constipation or diarrhea. Telephone interview with Resident #8's primary care provider (PCP) on 10/20/22 at 4:19pm revealed only getting half the ordered dose of Miralax would not be as effective for preventing or treating constipation for Resident #8. e. Review of Resident #8's physician's order dated 09/07/22 revealed an order for Tums EX 750mg chew 2 tablets (1500mg) once daily. (Tums EX is used to treat heartburn and acid reflux.) Review of Resident #8's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Tums EX 750mg chew 2 tablets one time a day for indigestion. -Tums EX was scheduled for administration at 8:00am. Observation of the 8:00am medication pass on 10/20/22 revealed: -The medication aide (MA) prepared and administered 1 Tums EX 750mg tablet to Resident #8 at 8:17am. -The resident was administered 1 Tums EX	D 358		

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D 358	Continued From page 26 750mg tablets instead of 2 tablets (1500mg) as ordered. Observation of Resident #8's medications on hand on 10/20/22 at 10:30am revealed: -There was a bottle of Tums EX 750mg chews dispensed on 08/22/22. -The instructions were to chew 2 tablets (1500mg) once daily. Interview with the MA on 10/20/22 at 10:32am revealed: -Resident #8 should have received 2 Tums EX 750mg tablets that morning on 10/20/22. -She overlooked the instructions to administer 2 tablets. Interview with Resident #8 on 10/20/22 at 9:54am revealed: -She did not know if she received one or two Tums EX tablets. -She did not complain of any current symptoms of acid reflux. Interview with the Health and Wellness Director (HWD) on 10/20/22 at 10:52am revealed: -The MAs should read the eMARs and medication labels and administer medications as ordered. -The MA should have administered 2 Tums EX 750mg tablets to Resident #8 instead of 1 tablet. Telephone interview with Resident #8's primary care provider (PCP) on 10/20/22 at 4:19pm revealed: -Resident #8 was supposed to receive 2 Tums EX 750mg tablets for control of acid reflux symptoms. -The resident's acid reflux symptoms could be worse if only receiving half the dose.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060042	A. BUILDING: _____ B. WING _____	R 10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEDDINGTON PARK	2404 PLANTATION CENTER DRIVE MATTHEWS, NC 28105

(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 27 The facility failed to administered medications as ordered to 3 residents observed during the medication passes on 10/19/22 and 10/20/22, resulting in 6 medication errors and a 23% error rate. The MA failed to mix and administer a barrier cream and an antifungal cream to the buttocks and groin area as ordered for Resident #6 who had redness to her buttocks and groin area, causing burning and discomfort for the resident. The MA failed to measure the correct dosage of a topical medication for pain and inflammation to Resident #7's knee putting the resident at risk of the medication being less effective for his pain. Three of Resident #8's medications were not administered as ordered during the observed medication pass on 10/20/22 including only half doses of her medications for constipation and acid reflux putting the resident at risk of those medications being less effective to treat her constipation and acid reflux. This failure was detrimental 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 10/20/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 4, 2022.	D 358		