STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081014	A. BUILDING _____ B. WING _____	05/04/2023

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

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 05/02/23 through 05/04/23.	D 000	The following is the Plan of Correction for Brookdale Forest City regarding the statement of deficiencies dated 5/25/2023. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the statement of deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to the identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	
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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (Resident #3) related to notifying the prescriber of incorrect and missed doses of a blood thinner and ensure labs were completed as ordered. The findings are: Review of Resident #3's current FL2 dated 11/21/22 revealed diagnoses included chronic pulmonary embolism (blockage of the pulmonary arteries that occurs when prior clots in these vessels do not dissolve over time despite treatment), hypertension, and chronic pain. a. Review of Resident #3's Nurse Practitioner's (NP) order dated 03/28/23 revealed: -There was an order to hold warfarin (used to treat and prevent blood clots) today (03/28/23). -There was an order to start warfarin 1mg 1 tablet every Monday, Wednesday, Friday, Saturday, and Sunday. -There was an order to start warfarin 2.5mg 1 tablet every Tuesday and Thursday.	D 273	10A NCAC 13 F .0902 Health Care Health and Wellness Director and/or designee will review Point Click Care daily for missing medication report for 60 days, and to continue reviewing weekly for 6 months. Health and Wellness Director and/or designee will immediately notify medical provider of any medication error.	6/30/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 6/2/2023

Reviewed and acknowledged Julie Grooms, RN 06/06/23

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D 273	Continued From page 1 -There was an order to repeat Prothrombin Time Test (PT)/International Normalized Ratio (INR) (a test used to evaluate blood clotting) on 04/04/23. Review of Resident #3's PT/INR results dated 04/04/23 revealed: -The PT was 22.5. -The INR was 2.27. Review of Resident #3's NP order dated 04/10/23 revealed: -There was an order to continue the current warfarin orders. -There was an order to repeat PT/INR on 04/18/23 and then every 2 weeks. Review of Resident #3's PT/INR dated 04/19/23 revealed: -The PT was 9.7. -The INR was 0.94 and was flagged "LOW" with a reference range 1.0-1.2. According to the National Institute of Health, the recommended therapeutic INR range is 2.0-3.0 to reduce the risk of blood clots. Review of Resident #3's April 2023 eMAR revealed: -There was an entry for warfarin 1mg 1 tablet on Monday, Wednesday, Friday, Sunday at 5:00pm. -There was an entry for warfarin 1mg 1 tablet on Monday, Wednesday, Friday, Saturday, Sunday at 6:00pm. -There was an entry for warfarin 2.5mg 1 tablet on Tuesday and Thursday scheduled at 5:00pm. -There was an entry for warfarin 2.5mg 1 tablet on Tuesday, Thursday, Saturday scheduled at 5:00pm. -From 04/04/23 to 04/14/23, warfarin was documented as not administered.	D 273		

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D 273	Continued From page 2 -On 04/15/23, warfarin 1mg should have been administered, but warfarin 2.5mg was documented as administered. -On 04/22/23, warfarin 1mg should have been administered, but warfarin 2.5mg was documented as administered. -On 04/29/23, warfarin 1mg should have been administered, but warfarin 2.5mg was documented as administered. -The warfarin was documented as administered as ordered for 14 occurrences out of 30 opportunities. Observation of Resident #3's medications on hand on 05/03/23 at 11:45am revealed: -There was one bubble pack of warfarin 2.5mg tablets with label directions to administer 1 tablet every Tuesday, Thursday, and Saturday with 2 tablets remaining of quantity of 12 tablets dispensed on 03/26/23. -There was one bubble pack of warfarin 2.5mg tablets with label directions to administer 1 tablet every Tuesday and Thursday with 8 tablets remaining of quantity of 8 tablets dispensed on 04/24/23. -There was one bubble pack of warfarin 1mg tablets with label directions to administer 1 tablet every Monday, Wednesday, Friday, Saturday, Sunday with 19 tablets remaining of quantity 20 tablets dispensed on 04/24/23. Telephone interview with the facility's contracted pharmacy representative on 05/03/23 at 4:09pm revealed: -They received a warfarin order for Resident #3 dated 03/28/23 for 2.5mg Tuesday and Thursdays and 1mg Mondays, Wednesday, Fridays, Saturdays and Sundays. -They received a warfarin order to continue current warfarin orders with no changes on	D 273		

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D 273	Continued From page 3 04/10/23. -The pharmacy dispensed a 30-day supply of warfarin 2.5mg and 1mg tablets for Resident #3 on 04/24/23. Review of Resident #3's incident report dated 04/14/23 revealed: -The nature of the incident was documented as missed medication. -The date of the Incident was 04/10/23-04/14/23. -The Health and Wellness Director (HWD was notified of the missed medication on 04/14/23 at 6:00pm. -Resident #3's NP was notified the missed medication on 04/17/23 at 10:00am by the HWD. Interview with the Resident Care Coordinator (RCC) on 05/04/23 at 8:05am revealed: -Resident #3's warfarin was not administered from 04/04/23 to 04/14/23, because one of their staff entered the warfarin orders to stop on 04/04/23 when the PT/INR was to be completed. -When Resident #3's warfarin order stopped on 04/04/23, it disappeared from Resident #3's eMAR. Review of an email communication between Resident #3's NP and the HWD and dated 04/21/23 revealed: -At 8:52am, the NP sent an email to the HWD indicating Resident #3's PT/INR (04/19/23) was "way off." -The NP wanted to know how many doses of warfarin Resident #3 had missed and the days warfarin was not administered. -At 4:37pm, the NP sent a second message asking the HWD if she was off work for "today" (04/21/23). -At 9:01pm, the HWD responded indicating the warfarin was not administered to Resident #3 for	D 273		

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D 273	Continued From page 4 5 days. Telephone interview with Resident #3's NP on 05/04/23 at 8:40am revealed: -The warfarin was ordered for Resident #3 due to the resident's history of pulmonary embolism and deep vein thrombosis (a blood clot in a deep vein, usually in the legs). -A therapeutic INR level for Resident #3 was between 2 and 3. -The HWD had notified her on 04/17/23 about 5 missed doses of warfarin from 04/10/23 to 04/14/23. -The staff did not notify her about the missed doses of warfarin from 04/04/23 to 04/09/23. -The facility did not have a warfarin order for Resident #3 after 04/04/23 which led to the missed doses. -The facility staff should have contacted her immediately when they did not have a warfarin order for Resident #3. -Resident #3 was at an increased risk of developing blood clots when she missed doses of warfarin or received incorrect doses of warfarin. -Resident #3 was at an increased risk of bleeding when she received incorrect doses of warfarin. Interview with the HWD on 05/04/23 at 9:30am revealed: -The facility's policy was to notify the prescriber "immediately" and obtain orders. -She was made aware by a MA on 04/14/23, Resident #3 was not receiving daily doses of warfarin. -She did not notify Resident #3's NP until 04/17/23 Resident #3 had missed warfarin from 04/10/23 to 04/14/23. -On 04/15/23, she continued the previous warfarin orders dated 04/10/23 and added it to Resident #3's eMAR until she could speak with	D 273		

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D 273	Continued From page 5	D 273		

the NP in person on 04/17/23.
-She knew Resident #3 was very sensitive to medications and she chose to restart the orders from 04/10/23 on 04/15/23 until she could speak with the NP on 04/17/23.
-She realized later she should have contacted the NP on 04/10/23 and asked for an order for a stat PT/INR, so the NP would know the amount of warfarin to safely restart.
-She realized later she should have asked the NP to clarify the order written 04/10/23 to include specific strength and times for continuing warfarin administration.

Interview with the Administrator on 05/02/23 at 4:00pm revealed:
-The RCC and HWD could get messages to the NP about resident health care concerns anytime through use of an application that sent messages directly to the NP.

b. Review of Resident #3's Nurse Practitioner's (NP) order dated 01/23/23 revealed there was an order to repeat Prothrombin Time Test (PT)/International Normalized Ratio (INR) (a test used to evaluate blood clotting) in 1 week (01/30/23).

Review of Resident #3's NP order dated 01/24/23 revealed there was an order to repeat PT/INR in 3 weeks (02/14/23).

Review of Resident #3's NP order dated 02/14/23 revealed there was an order to repeat PT/INR in 3 weeks (03/07/23).

Review of Resident #3's NP order dated 03/27/23 revealed there was an order for a stat (without delay) PT/INR.

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D 273	Continued From page 6 Review of Resident #3's NP order dated 03/28/23 revealed there was an order to repeat PT/INR on 04/04/23. Review of Resident #3's NP order dated 04/10/23 revealed there was an order to repeat PT/INR on 04/18/23 and then every 2 weeks (05/02/23). Review of Resident #3's record revealed: -There was no PT/INR completed on 02/14/23. -There was a PT/INR completed on 03/07/23; the PT result was 21.8; the INR result was 2.2. -There was a PT/INR completed on 03/28/23; the PT was 32; the INR was 3.29. -There was a PT/INR completed on 04/04/23; the PT was 22.5; the INR was 2.27. -There was a PT/INR completed on 04/18/23; the PT was 9.7; the INR was 0.94. -There was a PT/INR completed on 05/02/23; the PT was 16.7; the INR was 1.66. Interview with the Health and Wellness Director (HWD) on 05/02/23 at 3:50pm revealed: -A home health nurse was completing PT/INR labs for Resident #3 until 02/01/23 when they were unable to recertify Resident #3 to continue to receive home health services. -After 02/01/23, Resident #3's PT/INR labs were ordered and scheduled by the Nurse Practitioner with an outside contracted laboratory. -The PT/INR ordered for 02/14/23 "did not occur." -The facility did not take Resident #3 to an outside lab to get the PT/INR completed. -She did not know why the facility did not take Resident #3 to a lab to obtain the PT/INR on 02/14/23. -Neither she or any of the other staff notified the NP the contracted lab did not obtain the PT/INR as ordered on 02/14/23. -The facility did not receive results of labs that	D 273		

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D 273	Continued From page 7 were completed through the contracted lab unless they called and requested the results. Interview with the Administrator on 05/02/23 at 4:00pm revealed: -The Resident Care Coordinator (RCC) and HWD were responsible to ensure the labs were completed as ordered. -When the NP ordered a lab, the facility would receive a copy of the lab order that was sent to the contracted lab. -The RCC and NP were responsible to follow-up with the contracted lab to obtain a copy of the lab results. -When the home health agency recertification ended for Resident #3, the RCC and HWD failed to get them onto the NP's list for her to follow PT/INR and warfarin orders -Both the RCC and the HWD were made aware on 01/24/23 the home health agency involvement in obtaining PT/INR labs for Resident #3 would be ending on 02/01/23. -Resident #3 was not added to the NP's list for PT/INR follow-up until 03/07/23. -The RCC and HWD could have sent a message to the NP at anytime through the electronic message application to notify the NP about the needed PT/INR. -The NP was at the facility every Monday, so the RCC and NP could have communicated Resident #3's lab work need on those visits. -When the NP sent an order to the contracted lab and the contracted lab was unable to get to the facility to obtain the lab work in a timely manner, the NP would let the RCC and HWD know to obtain the lab somewhere else like at the hospital. Telephone interview with Resident #3's NP on 05/04/23 at 9:10am revealed:	D 273		

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D 273	Continued From page 8 -She was not made aware the PT/INR ordered to be completed on 02/14/23 was not completed until 03/06/23. -She was not made aware the home health agency had discharged Resident #3 on 02/01/23 and was not handling the PT/INR lab work until 03/06/23. The facility's failure to notify Resident #3's Nurse Practitioner of incorrect and missed doses of warfarin and a failure to obtain PT/INR as ordered on 02/14/23 increased the resident's risk of developing a blood clot or risk of bleeding due to not maintaining a therapeutic warfarin level. This failure was detrimental to the health, safety, and welfare of Resident #3 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/04/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 17, 2023.	D 273		
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.	D 358	10A NCAC 13F .1004(a) Medication Administration Health and Wellness Director and/or designee to audit coudmadin orders when labs drawn bi-weekly for 90 days, and to continue audit on all coumadin labs and orders monthly going forward. Health and Wellness Director and/or designee to complete chart audits to ensure accuracy of current medicaion orders.	6/30/2023

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D 358	Continued From page 9 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 prescribed for 2 of 5 sampled residents (#1 and #3) related to incorrect and missed doses of an anticoagulant medication used to treat and prevent blood clots (#3) and a medication used to treat high blood pressure (#1). The findings are: 1. Review of Resident #3's current FL2 dated 11/21/22 revealed diagnoses included chronic pulmonary embolism (blockage of the pulmonary arteries that occurs when prior clots in these vessels do not dissolve over time despite treatment), hypertension, and chronic pain. Review of Resident #3's NP order dated 01/24/23 revealed: -There was an order for warfarin 2.5mg take 1 tablet every Tuesday, Thursday, and Saturday. -There was an order for warfarin 1mg take 1 tablet every Monday, Wednesday, Friday, and Sunday. -There was an order to repeat PT/INR in 3 weeks (02/14/23). Review of Resident #3's NP order dated 02/14/23 revealed: -There was an order to continue current warfarin orders. -There was an order to repeat PT/INR in 3 weeks (03/07/23). Review of Resident #3's NP order dated 03/28/23 revealed: -There was an order to hold warfarin today	D 358		

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D 358	Continued From page 10 (03/28/23). -There was an order to start warfarin 1mg 1 tablet every Monday, Wednesday, Friday, Saturday, and Sunday. -There was an order to start warfarin 2.5mg 1 tablet every Tuesday and Thursday. -There was an order to repeat PT/INR on 04/04/23. Review of Resident #3's NP order dated 04/10/23 revealed: -There was an order to continue the current warfarin orders. -There was an order to repeat PT/INR on 04/18/23 and then every 2 weeks. Review of Resident #3's PT/INR dated 04/19/23 revealed: -The PT was 9.7. -The INR was 0.94 and was flagged "LOW" with a reference range 1.0-1.2. According to the National Institutes of Health, the recommended therapeutic INR range is 2.0-3.0 to reduce the risk of blood clots. Review of Resident #3's April 2023 eMAR revealed: -There was an entry for warfarin 1mg 1 tablet on Monday, Wednesday, Friday, Sunday at 5:00pm. -There was an entry for warfarin 1mg 1 tablet on Monday, Wednesday, Friday, Saturday, Sunday at 6:00pm. -There was an entry for warfarin 2.5mg 1 tablet on Tuesday and Thursday scheduled at 5:00pm. -There was an entry for warfarin 2.5mg 1 tablet on Tuesday, Thursday, Saturday scheduled at 5:00pm. -From 04/04/23 to 04/14/23, warfarin was documented as not administered.	D 358		

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D 358	Continued From page 11 -On 04/15/23, warfarin 1mg should have been administered, but warfarin 2.5mg was documented as administered. -On 04/22/23, warfarin 1mg should have been administered, but warfarin 2.5mg was documented as administered. -On 04/29/23, warfarin 1mg should have been administered, but warfarin 2.5mg was documented as administered. -The warfarin was documented as administered as ordered for 14 occurrences out of 30 opportunities. Observation of Resident #3's medications on hand on 05/03/23 at 11:45am revealed: -There was one bubble pack of warfarin 2.5mg tablets with label directions to administer 1 tablet every Tuesday, Thursday, and Saturday with 2 tablets remaining of quantity of 12 tablets dispensed on 03/26/23. -There was one bubble pack of warfarin 2.5mg tablets with label directions to administer 1 tablet every Tuesday and Thursday with 8 tablets remaining of quantity of 8 tablets dispensed on 04/24/23. -There was one bubble pack of warfarin 1mg tablets with label directions to administer 1 tablet every Monday, Wednesday, Friday, Saturday, Sunday with 19 tablets remaining of quantity 20 tablets dispensed on 04/24/23. Telephone interview with the facility's contracted pharmacy representative on 05/03/23 at 4:09pm revealed: -They received a warfarin order for Resident #3 dated 03/28/23 for 2.5mg Tuesday and Thursdays and 1mg Mondays, Wednesday, Fridays, Saturdays and Sundays. -They received a warfarin order to continue current warfarin orders with no changes on	D 358		

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D 358	Continued From page 12 04/10/23. -The pharmacy dispensed a 30-day supply of warfarin 2.5mg and 1mg tablets for Resident #3 on 04/24/23. Interview with the Resident Care Coordinator (RCC) on 05/04/23 at 8:05am revealed: -She and the medication aides (MA), the Special Care Coordinator (SCC), and the Health and Wellness Director (HWD) all received medication orders and were responsible for processing those orders. -When one of them received a medication order they were responsible for faxing the order to the pharmacy and then entering the medication order into the eMAR system. -The pharmacy never entered medication orders into the eMARs. -The pharmacy did not verify medication orders their staff entered into the eMAR. -The warfarin was not administered from 04/04/23 to 04/14/23, because one of their staff entered the warfarin orders to stop on 04/04/23 when the PT/INR was to be completed. -When Resident #3's warfarin order stopped on 04/04/23, it disappeared from Resident #3's eMAR. Review of Resident #3's incident report dated 04/14/23 revealed: -The HWD was notified of the missed medication on 04/14/23 at 6:00pm. -Resident #3's Nurse Practitioner (NP) was notified of the missed medication on 04/17/23 at 10:00am by the HWD. Telephone interview with Resident #3's NP on 05/04/23 at 8:40am revealed: -The warfarin was ordered for Resident #3 as a blood thinner due to the resident's history of	D 358		

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D 358	Continued From page 13 pulmonary embolism (when one or more arteries in the lungs become blocked by a blood clot) and deep vein thrombosis (a blood clot in a deep vein, usually in the legs). -The staff did not notify her about the missed doses of warfarin from 04/04/23 to 04/09/23. -The facility did not have a warfarin order for Resident #3 after 04/04/23 which led to the missed doses. -Resident #3 was at an increased risk of developing blood clots when she missed doses of warfarin or received incorrect doses of warfarin. -Resident #3 was at an increased risk of bleeding when she received incorrect doses of warfarin. Interview with the HWD on 05/04/23 at 9:30am revealed: -She was made aware by a MA on 04/14/23, Resident #3 was not receiving daily doses of warfarin. -She did not notify Resident #3's NP until 04/17/23 Resident #3 had missed warfarin from 04/10/23 to 04/14/23. -On 04/15/23, the HWD continued the previous warfarin orders dated 04/10/23 and added it to Resident #3's eMAR until she could speak with the NP on 04/17/23. Interview with the Administrator on 05/04/23 at 9:10am revealed: -The MA who saw the warfarin order was not on Resident #3's eMAR was responsible for contacting the NP to let her know. -Medication cart audits were performed weekly on third shift on all residents. -The MA's who were auditing the medication carts should have realized there was warfarin in the cart for Resident #3 and there was no order on the eMAR and should have relayed the information to the RCC and HWD.	D 358		

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D 358	Continued From page 14 2. Review of Resident #1's current FL2 dated 08/22/22 revealed: -Diagnoses included hypertension. -There was an order for amlodipine/benazepril 5-10mg (used to treat high blood pressure) take 1 capsule by mouth daily. Review of Resident #1's physician's orders dated 03/27/23 revealed: -There was an order to discontinue amlodipine/benazepril 5-10mg. -There was an order for benazepril/hydrochlorothiazide 10-12.5mg (used to treat high blood pressure) take 1 tablet daily. Interview with Resident #1 during the initial tour of the facility on 05/02/23 at 9:50am revealed she had high blood pressure that she took medication for and recently noticed she started wheezing and was short of breath at times. Observation of Resident #1 on 05/02/23 at 9:50am revealed: -She was wearing tan colored support stockings on both lower legs and had noticeable swelling in the ankles and both feet. -High pitched noises upon exhalation were heard when Resident #1 was talking. Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for amlodipine/benazepril 5-10mg take 1 capsule by mouth daily. - Amlodipine/benazepril 5-10mg was documented as administered daily from 03/01/23 through 03/28/23. -There was an entry for benazepril/hydrochlorothiazide 10-12.5mg take 1	D 358		

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D 358	Continued From page 15 tablet daily. - Benazepril/hydrochlorothiazide 10-12.5mg was documented as administered on 03/30/23 and 03/31/23. -There was no documentation amlodipine/benazepril 5-10mg or benazepril/hydrochlorothiazide 10-12.5mg was administered on 03/29/23. Review of Resident #1's April 2023 eMAR revealed: -There was an entry for benazepril/hydrochlorothiazide 10-12.5mg take 1 tablet daily. - Benazepril/hydrochlorothiazide 10-12.5mg was documented as administered daily from 04/01/23 through 04/30/23. Review of Resident #1's 05/01/23 and 05/02/23 eMAR revealed: -There was an entry for benazepril/hydrochlorothiazide 10-12.5mg take 1 tablet daily. - Benazepril/hydrochlorothiazide 10-12.5mg was documented as administered daily on 05/01/23 and 05/02/23. Observation of Resident #1's medications on hand on 05/03/23 at 11:05am revealed: -There was a medication bubble pack labeled amlodipine/benazepril 5-10mg take 1 capsule by mouth daily with 6 capsules remaining. - Benazepril/hydrochlorothiazide 10-12.5mg was not available for administration. Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 05/03/23 at 11:20am revealed: -She thought Resident #1's benazepril/hydrochlorothiazide 10-12.5mg was	D 358		

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D 358	Continued From page 16 available for administration. -She did not pay attention to the medication name or dosage when she administered the amlodipine/benazepril 5-10mg to Resident #1 because she thought the amlodipine/benazepril 5-10mg was the same medication as benazepril/hydrochlorothiazide 10-12.5mg because both medications had "benazepril" in the name. -The third shift MA supervisors were responsible for weekly medication cart audits. -She and the MA supervisors were responsible for removing discontinued medications from the medication cart and making sure medications ordered were available for administration by requesting the medication refill from the facility's contracted pharmacy. Telephone interview with the facility's contracted pharmacy on 05/03/23 at 11:47am revealed: -Resident #1's amlodipine/benazepril 5-10mg was last dispensed on 03/06/23 in the quantity of 28 capsules and was discontinued on 03/29/23. -Resident #1's benazepril/hydrochlorothiazide 10-12.5mg was dispensed once on 03/29/23 in the quantity of 15 tablets. -Resident #1's benazepril/hydrochlorothiazide would have been available to administer from 03/30/23 through 04/13/23 if it was administered as ordered. -The facility was responsible for requesting a refill for Resident #1's benazepril/hydrochlorothiazide 10-12.5mg and the pharmacy did not receive a refill request. Telephone interview with Resident #1's primary care provider (PCP) on 05/03/23 at 12:09pm revealed: -She discontinued Resident #1's amlodipine/benazepril 5-10mg on 03/27/23	D 358		

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D 358	Continued From page 17 because she thought it caused swelling in Resident #1's legs, ankles, and feet. -She ordered Resident #1 benazepril/hydrochlorothiazide 10-12.5mg on 03/27/23 to treat Resident #1's high blood pressure to see if changing the blood pressure medication would stop the swelling. -Resident #1 being administered the amlodipine/benazepril 5-10mg instead of the ordered benazepril/hydrochloride could cause continued swelling in the legs, ankles, and feet and may be responsible for the high-pitched noises with Resident #1's breathing due to excess swelling. -She expected the facility staff to administer Resident #1's medications as ordered. Interview with the Administrator on 05/04/23 at 9:10am revealed: -The facility used a medication order tracking form for all new medication orders to make sure any changes to a medication including dosage, discontinuation, or new order were completed. -The medication order tracking form documentation began with the MA and then was checked by the RCC, and final check was completed by the Health and Wellness Director. -There was not a medication order tracking form completed for Resident #1's amlodipine/benazepril 5-10mg to be discontinued or an order to begin benazepril/hydrochloride 10-12.5mg. -She did not know why the medication order tracking form was not completed. -She did not know Resident #1's benazepril/hydrochloride medication was not available for administration or that staff administered the amlodipine/benazepril 5-10mg to Resident #1 after the medication was discontinued.	D 358		

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D 358	Continued From page 18 -Medication cart audits were completed on 03/30/23, 04/06/23, 04/13/23, 04/20/23. -The medication cart audit was not completed on 04/27/23 and she did not know why it was not done. -The night shift MA supervisors should have removed the discontinued amlodipine/benazepril 5-10mg for Resident #1 with the 03/30/23 cart audit. -The MAs were responsible for requesting medication refills from the pharmacy when the medication was unavailable for administration. -She expected the facility staff to administer resident's medications as ordered including the resident received the correct medication and dosage. The facility's failure to ensure medications were administered as ordered for Resident #3, resulting in a sub-therapeutic blood clotting level due to missed and incorrect doses of the resident's anticoagulant medication placing Resident #3, who had a history of a blood clot in the lung, at increased risk of bleeding and developing additional blood clots and for Resident #1 who continued to be administered a blood pressure medication that was discontinued, causing continued swelling of the lower legs, ankles and feet and possible wheezing. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/03/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 17, 2023.	D 358		

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D 367	Continued From page 19	D 367		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure electronic medication administration records (eMARs) were complete and accurate for 1 of 5 sampled residents (Resident #1) related to a medication used to treat high blood pressure. The findings are: Review of Resident #1's current FL2 dated 08/22/22 revealed:	D 367	10A NCAC 13F .1004(j) Medication Administration Health and Wellness Director and/or designee will ensure that new order tracking form is utilized with orders to ensure accuracy. Health and Wellness Director and/or designee will ensure that weekly cart audits are completed.	6/30/2023

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D 367	Continued From page 20 -Diagnoses included hypertension. -There was an order for amlodipine/benazepril 5-10mg (used to treat high blood pressure) take 1 capsule by mouth daily. Review of Resident #1's physician's orders dated 03/27/23 revealed: -There was an order to discontinue amlodipine/benazepril 5-10mg. -There was an order for benazepril/hydrochlorothiazide 10-12.5mg (used to treat high blood pressure) take 1 tablet daily. Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for amlodipine/benazepril 5-10mg take 1 capsule by mouth daily. - Amlodipine/benazepril 5-10mg was documented as administered daily from 03/01/23 through 03/28/23. -There was an entry for benazepril/hydrochlorothiazide 10-12.5mg take 1 tablet daily. - Benazepril/hydrochlorothiazide 10-12.5mg was documented as administered on 03/30/23 and 03/31/23. -There was no documentation amlodipine/benazepril 5-10mg or benazepril/hydrochlorothiazide 10-12.5mg was administered on 03/29/23. Review of Resident #1's April 2023 eMAR revealed: -There was an entry for benazepril/hydrochlorothiazide 10-12.5mg take 1 tablet daily. - Benazepril/hydrochlorothiazide 10-12.5mg was documented as administered daily from 04/01/23 through 04/30/23.	D 367		

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D 367	Continued From page 21 Review of Resident #1's 05/01/23 and 05/02/23 eMAR revealed: -There was an entry for benazepril/hydrochlorothiazide 10-12.5mg take 1 tablet daily. - Benazepril/hydrochlorothiazide 10-12.5mg was documented as administered daily on 05/01/23 and 05/02/23. Observation of Resident #1's medications on hand on 05/03/23 at 11:05am revealed: -There was a medication bubble pack labeled amlodipine/benazepril 5-10mg take 1 capsule by mouth daily with 6 capsules remaining. - Benazepril/hydrochlorothiazide 10-12.5mg was not available for administration. Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 05/03/23 at 11:20am revealed: -She thought Resident #1's benazepril/hydrochlorothiazide 10-12.5mg was available for administration. -She did not pay attention to the medication name or dosage when she administered the amlodipine/benazepril 5-10mg to Resident #1 because she thought the amlodipine/benazepril 5-10mg was the same medication as benazepril/hydrochlorothiazide 10-12.5mg because both medications had "benazepril" in the name. -She was responsible for administering the correct medications ordered and signing the eMAR the medications as administered or not administered if the medication was unavailable. Telephone interview with the facility's contracted pharmacy on 05/03/23 at 11:47am revealed: -The facility was responsible for adding or	D 367		

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D 367	Continued From page 22 removing medication entries on the eMAR. -Resident #1's amlodipine/benazepril 5-10mg was last dispensed on 03/06/23 in the quantity of 28 capsules and was discontinued on 03/29/23. -Resident #1's benazepril/hydrochlorothiazide 10-12.5mg was dispensed once on 03/29/23 in the quantity of 15 tablets. -Resident #1's benazepril/hydrochlorothiazide would have been available to administer from 03/30/23 through 04/13/23 if it was administered as ordered. Interview with the Administrator on 05/04/23 at 9:10am revealed: -She did not know why the MAs documented on the eMAR administering Resident #1's benazepril/hydrochloride from 04/13/23 through 05/02/23 when the medication was unavailable. -Medication cart audits were completed on 03/30/23, 04/06/23, 04/13/23, 04/20/23 and included checking the eMARs for accuracy. -The medication cart and eMAR audit was not completed on 04/27/23 and she did not know why it was not done. -She expected the facility staff to administer resident's medications as ordered and document on the eMAR the medications as administered or not administered if the medication was unavailable.	D 367		