PRINTED: 05/19/2023 FORM APPROVED

	<u>f Health Service Requ</u>	T				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVI	
	HAL081014		B. WING		05/04/20	023
NAME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		493 PINE	Y RIDGE ROAL	D		l
BROOKDA	LE FOREST CITY		CITY, NC 2804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	DBE C	(X5) COMPLETE DATE
D 000		sure Section conducted an 02/23 through 05/04/23.	D 000	The following is the Plan of Co Brookdale Forest City regardin statement of deficiencies dated This plan of correction is not to construed as an admission of co	g the d 5/25/2023. be or agreement	
D 273	to meet the routine a of residents.  This Rule is not met TYPE B VIOLATION  Based on interviews facility failed to ensure meet the acute healt sampled residents (Fnotifying the prescrib doses of a blood thin completed as ordere.  The findings are:  Review of Resident and pulmonary embolism arteries that occurs a vessels do not dissoure treatment), hypertental Review of Resided (NP) order dated 03/1-There was an order treat and prevent bloothers was an order the side of the rewas an order the rewas an order the side of the rewas an order the rewas and rewas an order the rewas an order the rewa	2 Health Care assure referral and follow-up and acute health care needs as evidenced by: and record reviews, the re referral and follow-up to the care needs of 1 of 5 Resident #3) related to the referral and ensure labs were d. #3's current FL2 dated agnoses included chronic to (blockage of the pulmonary when prior clots in these live over time despite sion, and chronic pain.  and #3's Nurse Practitioner's	D 273	with the findings and conclusion statement of deficiencies, or an sanction or fine. Rather, it is suconfirmation of our ongoing efficiency with statutory and regular requirements. In this document outlined specific actions in respect the identified issues. We have provided a detailed response to allegation or finding, nor have mitigating factors. We remain to the delivery of quality health services and will continue to mand improvement to satisfy that the services and will continue to mand improvement to satisfy that the services and will review Point Click daily for missing medication regularly, and to continue reviewing for 6 months.  Health and Wellness Director and designee will immediately notify provider of any medication error of the services and medication error of the services and will immediately notify provider of any medication error of the services and the services	ny related as orts to latory at, we have conse to not o each we identified care ake changes to objective.  Care ort for 60 g weekly and/or y medical	/30/2023
Division of H	tablet every Tuesday	to start warfarin 2.5mg 1 y and Thursday.  VSUPPLIER REPRESENTATIVE'S SIGNATU		TITLE		) Defite

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

**FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ B. WING HAL081014 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **493 PINEY RIDGE ROAD BROOKDALE FOREST CITY** FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 273 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, Salurday, 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

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-From 04/04/23 to 04/14/23, warfarin was documented as not administered.

PRINTED: 05/19/2023 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_\_ HAL081014 B. WING 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE: 2IP CODE **493 PINEY RIDGE ROAD BROOKDALE FOREST CITY** FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) IO (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 273 Continued From page 2 D 273 -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:

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-They received a warfarin order for Resident #3 dated 03/28/23 for 2.5mg Tuesday and Thursdays and 1mg Mondays, Wednesday,

-They received a warfarin order to continue current warfarin orders with no changes on

Fridays, Saturdays and Sundays.

MALOSTOTA  MANE OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZP CODE  433 PINEY RIDGE ROAD  FOREST CITY  433 PINEY RIDGE ROAD  FOREST CITY, NO 2843  PROVIDERS PLAN OF CORRECTION  GRAPH OF CORRECTION OF CORRECTION  (CACH OPPOIGNAY MAY THE PRESCREDED BY FULL  PRESTAX  TAG  D 273  Continued From page 3  D4/10/23,  The pharmacy dispensed a 30-day supply of warfarin 2.5mg and 1mg tablets for Resident #3 on 04/24/23.  The halther of the incident was documented as missed medication.  The date of the incident was 04/10/23-04/14/23.  The Haalth and Wellness Director, (HWD was notified the missed medication on 04/14/23 at 10:00am by the HWD.  Interview with the Resident Care Coordinator (RCC) on 05/04/23 to 94/14/23, because one of their staff entered the warfarin orders to stop on 04/04/23 warfarin orders to stop on 04/04/23 warfarin orders to stop on 04/04/23, it disappeared from Resident #3's warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered the warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered the warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered the warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered the warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered the warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered the warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered the warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered the warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered the warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered warfarin orders to stop on 04/04/23, it disappeared from Resident #3's entered warfarin orders to stop on 04/04/23, it disappeared from Resident #3's ente		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
BROKOALE FOREST CITY  433 PINEY RIDGE ROAD FOREST CITY, NC. 28043    CACHO PRICERY   SUMMARY STATEMENT OF DEFICIENCIES   FOREST CITY, NC. 28043   PROVIDER'S PLAN OF CORRECTION   (EACH DEFICIENCY MUST are PRECEDED BY FLAL   FACULATION OF LISE DEFINITING INFORMATION)   TAG   PROVIDER'S PLAN OF CORRECTION   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERBLECO) TO THE PROPRIATE OME			HAL081014	B. WING		05/04/2023
SUMMARY STATEMENT OF DEPICIENCIES   DEPICIENCY   PREST CITY, NO. 28043	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	É, ZIP CODE	
PREFIX TAG  D 273  Continued From page 3  O/1/10/23.  -The pharmacy dispensed a 30-day supply of warfarin 25-mg 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 on 04/14/23 at elogom.  -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 elogom.  -Resident #3's NP was notified the missed medication on 04/14/23 at elogom.  -Resident #3's at 10.00am by the HWD.  Interview with the Resident Care Coordinator (RCC) on 05/04/23 at 80.5am revealed:  -Resident #3's warfarin was not administered from 04/04/23 to 04/14/23.  -Review of an email communication between Resident #3's warfarin order stopped on 04/04/23, this papeared from Resident #3's warfarin order stopped on 04/04/23. Was affair order stopped on 04/04/23, the NP sent an email to the HWD indicating Resident #3's PTINR (04/19/23) was "way off."  -The NP wanted to know how many doses of warfarin was not administered.  -At 8:52-am, the NP sent an email to the HWD indicating Resident #3's had missed and the days warfarin was not administered.  -At 8:52-am, the NP sent an email to the HWD indicating Resident #3's had missed and the days warfarin was not administered.  -At 4:37-pm, the NP sent a second message asking the HWD if she was off work for "today" (04/21/23).  -At 9-01-pm, the HWD responded indicating the	BROOKD	ALE FOREST CITY				
04/10/23The 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 medicationThe date of title incident was 04/10/23-04/14/23The heath and Wellness Director (HWD was notified of the missed medication on 04/14/23 at 6.00pmResident #3's NP was notified the missed medication on 04/11/23 at 10:00pm 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 slop on 04/04/23 when the PT/INR was to be completedWhen Resident #3's warfarin order stopped on 04/04/23, till 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 a second message asking the HWD at officiating Resident #3's had missed and the days warfarin was not administeredAt 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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETE
	D 273	D4/10/23.  -The pharmacy disper warfarin 2.5mg and 1 on 04/24/23.  Review of Resident # 04/14/23 revealed: -The nature of the incomissed medicationThe date of the Incidentified of the missed 6:00pmResident #3's NP warmedication on 04/17/  Interview with the Resident #3's warfart from 04/04/23 to 04/13 to 04/14/23 when the Perwhen Resident #3's 04/04/23, it disappease MAR.  Review of an ermail of Resident #3's NP and 04/21/23 revealed: -At 8:52am, the NP sindicating Resident #3's warfarin Was not administration of the NP saking the HWD if shift (04/21/23)At 9:01pm, the HWD	nsed a 30-day supply of mg tablets for Resident #3  3's incident report dated sident was documented as lent was 04/10/23-04/14/23, mess Director (HWD was medication on 04/14/23 at less notified the missed 23 at 10:00am by the HWD.  sident Care Coordinator to 8:05am revealed: fin was not administered 14/23, because one of their farin orders to stop on T/INR was to be completed, warfarin order stopped on red from Resident #3's formunication between the HWD and dated the HWD and dated sent an email to the HWD 13's PT/INR (04/19/23) was now how many doses of had missed and the days ninistered. Sent a second message he was off work for "today" to responded indicating the	D 273		

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING B. WING HAL081014 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **493 PINEY RIDGE ROAD** BROOKDALE FOREST CITY FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 273 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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL081014	B. WING		05/04/2023	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STAT	'E, ZIP CODE	0010472020	
BBOOKO	ALE CORECT OUT		RIDGE ROAD			
BROOKD	ALE FOREST CITY	FOREST C	TY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICION (PROPERTY)	D BE COMPLETE	
D 273	medications and she from 04/10/23 on 04/with the NP on 04/17 -She realized later sh NP on 04/10/23 and PT/INR, so the NP w warfarin to safely resulting the order with specific strength and administration.  Interview with the Additional to the Additional strength and administration.  Interview with the Additional to the Additional Head of the NP.  Interview of Resident (NP) order to repeat Prothe (PT)/International Not used to evaluate block (01/30/23).  Review of Resident in revealed there was a 3 weeks (02/14/23).  Review of Resident in revealed there was a 3 weeks (03/07/23).  Review of Resident in revealed there was a 3 weeks (03/07/23).	04/17/23. #3 was very sensitive to chose to restart the orders 15/23 until she could speak /23. he should have contacted the asked for an order for a stat ould know the amount of tart. he should have asked the NP ritten 04/10/23 to include times for continuing warfarin ministrator on 05/02/23 at could get messages to the palth care concerns anytime plication that sent messages  11 #3's Nurse Practitioner's 23/23 revealed there was an	D 273			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		1 1 1 1 1 1	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		HAL081014	B, WING	<del></del>	05	5/04/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE			
BROOKD	ALE FOREST CITY	493 PINEY	RIDGE ROAD				
BROOKD	REE POREST OFF	FOREST C	ITY, NC 28043			<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 273	Continued From pag	e 6	D 273				
	Review of Resident a revealed there was a 04/04/23.	#3's NP order dated 03/28/23 in order to repeat PT/INR on					
	revealed there was a	#3's NP order dated 04/10/23 in order to repeat PT/INR on very 2 weeks (05/02/23).	,				
	-There was a PT/INF PT result was 21.8; t -There was a PT/INF PT was 32; the INR -There was a PT/INF PT was 22.5; the INF -There was a PT/INF PT was 9.7; the INR	R completed on 02/14/23. R completed on 03/07/23; the he INR result was 2.2. R completed on 03/28/23; the was 3.29. R completed on 04/04/23; the R was 2.27. R completed on 04/18/23; the was 0.94.					
	PT was 16.7; the fN/I Interview with the He (HWD) on 05/02/23: -A home health nurs labs for Resident #3 were unable to recei to receive home hea -After 02/01/23, Res	ealth and Wellness Director at 3:50pm reveated: e was compteting PT/INR until 02/01/23 when they rtify Resident #3 to continue					
	with an outside conti- The PT/INR ordered The facility did not to outside lab to get the She did not know when the she or a lab outside the she or any on the contracted lab ordered on 02/14	racted laboratory. d for 02/14/23 "did not occur," ake Resident #3 to an e PT/INR completed, thy the facility did not take to obtain the PT/INR on of the other staff notified the					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL081014	B. WING		05/04/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	E, ZIP CODE		
BROOKD	ALE FOREST CITY	493 PINEY	RIDGE ROAD			
DICOND	ALE FOREST OFF	FOREST	ITY, NC 28043			
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D 273			D 273			
	,	igh the contracted lab d requested the results.	ļ 			
	Interview with the Adi 4:00pm revealed:	ministrator on 05/02/23 at				
	were responsible to e					
		d a lab, the facility would				
	the contracted lab.	lab order that was sent to				
	-The RCC and NP were responsible to follow-up					
-	with the contracted lab to obtain a copy of the lab results.					
		Ith agency recertification				
		3, the RCC and HWD failed				
	PT/INR and warfarin	NP's list for her to follow orders				
	-Both the RCC and th	ne HWD were made aware				
		e health agency involvement abs for Resident #3 would				
		t added to the NP's list for				
		could have sent a message				
		through the electronic to notify the NP about the				
	-The NP was at the fi	acility every Monday, so the ave communicated Resident				
	#3's lab work need o	n those visits. In order to the contracted lab	}			
		ib was unable to get to the				
	*	ab work in a timely manner,				
	the NP would let the obtain the lab somev	RCC and HWD know to		~		
	hospital.	my y give into as into				
	Telephone interview 05/04/23 at 9:10am i	with Resident #3's NP on revealed:				

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: \_ HAL081014 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 493 PINEY RIDGE ROAD BROOKDALE FOREST CITY FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** REGULATORY OR USC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 273 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. 10A NCAC 13F .1004(a) Medication D 358 D 358 10A NCAC 13F .1004(a) Medication Administration Administration Health and Wellness Director and/or designee to audit coudmadin orders 10A NCAC 13F .1004 Medication Administration when labs drawn bi-weekly for 90 days, (a) An adult care home shall assure that the and to continue audit on all coumadin preparation and administration of medications, 6/30/2023 labs and orders monthly going forward. prescription and non-prescription, and treatments by staff are in accordance with: Health and Wellness Director and/or (1) orders by a licensed prescribing practitioner designee to complete chart audits to which are maintained in the resident's record; and ensure accuracy of current medicaion (2) rules in this Section and the facility's policies brders. and procedures.

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING:		СОМ	PLETED	
		HAL081014	B. WING		0!	5/04/2023	
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NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STATI	E, ZIP COOE			
BROOKDA	ALE FOREST CITY		RIDGE ROAD				
			ITY, NC 28043				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(XS) COMPLETE DATE	
D 358	Continued From page	9 9	D 358	1		ĭI.	
	This Rule is not met TYPE B VIOLATION  Based on observation reviews, the facility famedications as presoresidents (#1 and #3) missed doses of an aused to treat and premedication used to tr.  The findings are:  1. Review of Resider 11/21/22 revealed diapulmonary embolism	as evidenced by:  ns, interviews, and record alied to administer cribed for 2 of 5 sampled ) related to incorrect and anticoagulant medication vent blood clots (#3) and a eat high blood pressure (#1).  at #3's current FL2 dated agnoses included chronic (blockage of the pulmonary when prior clots in these					
	Review of Resident and revealed: -There was an order tablet every TuesdayThere was an order tablet every Monday. SundayThere was an order (02/14/23). Review of Resident and revealed: -There was an order ordersThere was an order (03/07/23).	for warfarin 2.5mg take 1 to the third the continue current warfarin to repeat PT/INR in 3 weeks  #3's NP order dated 02/14/23  to continue current warfarin to repeat PT/INR in 3 weeks					
		to hold warfarin today					

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL081014	B. WING		05/0	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	TE, ZIP CODE		-
BROOKD	ALE FOREST CITY		RIDGE ROAD			
			ITY, NC 28043	<u>:.</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(XS) COMPLETE DATE
D 358	Continued From page	e 10	D 358			
	every Monday, Wedn and Sunday.	•				
	revealed:	•				
	revealed: -The PT was 9.7The INR was 0.94 a reference range 1.0- According to the Nat	#3's PT/INR dated 04/19/23  Ind was flagged "LOW" with a 1.2.  Ional Institutes of Health, the peutic INR range is 2.0-3.0 to				
	revealed: -There was an entry Monday, Wednesday -There was an entry Monday, Wednesday at 6:00pmThere was an entry on Tuesday and Thu -There was an entry on Tuesday, Thursday 5:00pm.	for warfarin 1mg 1 tablet on y, Friday, Sunday at 5:00pm. for warfarin 1mg 1 tablet on y, Friday, Saturday, Sunday for warfarin 2.5mg 1 tablet rsday scheduled at 5:00pm. for warfarin 2.5mg 1 tablet ay, Saturday scheduled at 4:00pm.				

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL081014	B. WING		0.5	/04/2023
			200522 007/ 07/25	70.000	1 05	10412023
NAME OF P	ROVIDER OR SUPPLIER		OORESS, CITY, STATE E <b>Y RIDGE ROAD</b>	, ZIP CODE		
BROOKD	ALE FOREST CITY		CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	On 04/15/23, warfar administered, but wa documented as admi -On 04/22/23, warfar administered, but wa documented as admi -On 04/29/23, warfar administered, but wa documented as admi -The warfarin was do as ordered for 14 occopportunities.  Observation of Resid hand on 05/03/23 at -There was one bubt tablets with label dire every Tuesday, Thur tablets remaining of dispensed on 03/26/-There was one bubt tablets with label dire every Tuesday and Tremaining of quantity 04/24/23There was one bubt tablets with label dire every Tuesday and Tremaining of quantity 04/24/23There was one bubt tablets with label dire every Monday, Wedi Sunday with 19 tablet tablets dispensed on Telephone interview pharmacy representative aled: -They received a wa dated 03/28/23 for 2 Thursdays and 1mg Fridays, Saturdays as	in 1mg should have been rfarin 2.5mg was nistered. in 1mg should have been rfarin 2.5mg was inistered. in 1mg should have been rfarin 2.5mg was inistered. in 1mg should have been rfarin 2.5mg was inistered. In 1mg should have been rfarin 2.5mg was inistered. In 1mg should have been rfarin 2.5mg was inistered. In 1mg sections to administer 1 tablet sday, and Saturday with 2 quantity of 12 tablets 23. In 1mg sections to administer 1 tablet 1mursday with 8 tablets of 8 tablets dispensed on the pack of warfarin 1mg sections to administer 1 tablet 1mursday with 8 tablets of 8 tablets dispensed on the pack of warfarin 1mg sections to administer 1 tablet 1mursday. Friday, Saturday, at 1mg remaining of quantity 20 104/24/23.  With the facility's contracted active on 05/03/23 at 4:09pm rfarin order for Resident #3.5mg Tuesday and Mondays, Wednesday,	D 358			

Division of Health Service Regulation

PRINTED 05/19/2023 **FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING\_ HAL081014 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **493 PINEY RIDGE ROAD BROOKDALE FOREST CITY** FOREST CITY, NC 28043 (X\$) COMPLETE DATE **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG TAG D 358 Continued From page 12 D 358 04/10/23

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.	

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Telephone interview with Resident #3's NP on

-The warfarin was ordered for Resident #3 as a blood thinner due to the resident's history of

05/04/23 at 8:40am revealed:

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING HAL081014 05/04/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **493 PINEY RIDGE ROAD BROOKDALE FOREST CITY** FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR USC IDENTIFYING INFORMATION) TAG DEFICIENCY) D 358 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 -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

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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.

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED A. BUILDING: B WING HAL081014 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **493 PINEY RIDGE ROAD BROOKDALE FOREST CITY** FOREST CITY, NC 28043 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY D 358 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 amfodipine/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 amtodiplne/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

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL081014 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **493 PINEY RIDGE ROAD BROOKDALE FOREST CITY** FOREST CITY, NC 28043 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 358 Continued From page 15 D 358 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.

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revealed:

-She thought Resident #1's

Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 05/03/23 at 11:20am

beлazeprit/hydrochlorothiazide 10-12.5mg was

**FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL081014 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **493 PINEY RIDGE ROAD BROOKDALE FOREST CITY** FOREST CITY, NC 28043 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL JEACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) D 358 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/hydrochlorothlazide 10-12.5mg and the pharmacy did not receive a refill request. Telephone interview with Resident #1's primary

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revealed:

care provider (PCP) on 05/03/23 at 12:09pm

amlodipine/benazepril 5-10mg on 03/27/23

-She discontinued Resident #1's

6899

		A. BUILDING:		(X3) DATE SURVEY COMPLETED	
<u> </u>	HAL081014	B. WING		05	/04/2023
ROVIDER OR SUPPLIER	STREET AD	DORESS, CITY, STATE	E, ZIP CODE		
M E FOREST CITY	493 PINE	Y RIDGE ROAD			
ALL FOREST OFF	FOREST	CITY, NC 28043			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
because she thought Resident #1's legs, a -She ordered Reside benazepril/hydrochloros/27/23 to treat Respressure to see if chamedication would sto -Resident #1 being a amlodipine/benazepril/hocontinued swelling in and may be responsinoises with Resident excess swellingShe expected the fare Resident #1's medication for all new med any changes to a mediscontinuation, or not -The medication orded ocumentation begat checked by the RCC	it caused swelling in hales, and feet. In #1 orthiazide 10-12.5mg on ident #1's high blood anging the blood pressure in the swelling. It is stated to the difference of the process of the high-pitched with the legs, ankles, and feet ble for the high-pitched with streathing due to cility staff to administer strong as ordered.  In the legs of the process of the proce	D 358			
-There was not a me completed for Reside amlodipine/benazepa	dication order tracking form ent #1's il 5-10mg to be discontinued	}			
10-12.5mgShe did not know w tracking form was no -She did not know R benazepril/hydrochk available for adminis	ny the medication order t completed. esident #1's ride medication was not tration or that staff				
	Continued From page because she thought Resident #1's legs, ar -She ordered Resider benazepril/hydrochlor 03/27/23 to treat Resipressure to see if chamedication would sto -Resident #1 being aramlodipine/benazepril/hydrochlor ordered benazepril/hydrochlor ordered by the RCC completed for Reside amlodipine/benazepril/hydrochlor ordered begin to -12.5mg.  -She did not know with tracking form was not she did not know Rebenazepril/hydrochlor available for adminis administered the ambiguitation.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 lhe 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 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 was not available for administration or that staff administered the emlodiplne/benazepril 5-10mg to Resident #1 after the medication was	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCE MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17  D 358  Decause she thought it caused swelling in Resident #1's legs, ankles, and feetShe 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 swellingResident #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 swellingShe 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 completedThe medication order tracking form documentation began with the MA and then was checked by the RCC, and final check was completed for Resident #1's amlodipine/benazepril 5-10mg to be discontinued or an order to begin benazepril/hydrochloride 10-12.5mgShe did not know why the medication order tracking form was not completedShe 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	SUMMARY STATEMENT OF DEFICIENCIES  [REACH DEFICIENCY MUST AE PRECEDED BY PULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17  because she thought it caused swelling in Resident #1's legs, ankles, and feet.  -She ordered Resident #1 benazeprill/hydrochlorothiazide 10-12.5mg on 03/27/23 to treat Resident #1's high 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 he legs, ankles, and feet and may be responsible for the high-pitched noises with Resident #1's breathing due to excess welling.  -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 RCC and final check was 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	SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  (EACH OFFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR USC IDENTIFYING INFORMATION)  COntinued From page 17  D 358  COntinued From page 17  because she thought it caused swelling in Resident #1's legs, ankles, and feet.  -She ordered Resident #1's high blood pressure to see if changing the blood pressure medication would stop the swelling.  -Resident #1's being administered the amilodipine/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 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 amilodipine/benazepril 5-10mg to be discontinued or an order to begin benazepril/hydrochloride 10-12,5mg.  -She did not know Wesident #1's benazepril/hydrochloride medication was not available for administration or that staff administered the amilodipine/benazepril 5-10mg to Resident #1 after the medication was

Division of Health Service Regulation

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A. BUILDING B. WING HAL081014 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **493 PINEY RIDGE ROAD BROOKDALE FOREST CITY** FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION. (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 358 Continued From page 18 D 358 -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,

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING B WING HAL081014 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **493 PINEY RIDGE ROAD BROOKDALE FOREST CITY** FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FURT. **IEACH CORRECTIVE ACTION SHOULD BE** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 367 Continued From page 19 D 367 D 367 10A NCAC 13F .1004(j) Medication D 367 10A NCAC 13F .1004(j) Medication Administration Administration 10A NCAC 13F ,1004 Medication Administration Health and Wellness Director and/or (j) The resident's medication administration designee will ensure that new order 6/30/2023 record (MAR) shall be accurate and include the tracking form is utilized with orders to following: ensure accuracy. (1) resident's name: (2) name of the medication or treatment order; Health and Wellness Director and/or (3) strength and dosage or quantity of medication designee will ensure that weekly cart audits are completed. 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 initiats 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:

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING: \_\_\_ B. WING \_\_ HAL081014 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **493 PINEY RIDGE ROAD BROOKDALE FOREST CITY** FOREST CITY, NC 28043

	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
	REGULATORY OR LSC IDENTIFYING INFORMATION)	1 1	CROSS-REFERENCED TO THE APPROPRIATE	DATE
	-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.		<i>*</i>	

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING. B, WING HAL081014 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY, STATE, ZIP CODE **493 PINEY RIDGE ROAD BROOKDALE FOREST CITY** FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 367 Continued From page 21 D 367 Review of Resident #1's 05/01/23 and 05/02/23 eMAR revealed: -There was an entry for benazepril/hydrochlorothlazide 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:

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-The facility was responsible for adding or

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: HAL081014 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **493 PINEY RIDGE ROAD** BROOKDALE FOREST CITY FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 367 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.

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