STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025012	A. BUILDING: _____ B. WING _____	08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NEW BERN	1336 SOUTH GLENBURNIE ROAD NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on August 19-21, 2015.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, record review, and interview, the facility failed to notify the physician of increased leg swelling and redness around a leg wound until at least 8 days after swelling and pain were documented; failed to schedule a follow-up appointment related to an emergency room visit for leg swelling, redness, and weeping; and failed to make a dermatology appointment for excessive dry skin/flaking and warts on left arm and hand for 1 of 5 residents (#1) sampled for health care. The findings are: A. Review of Resident #1's current FL-2 dated 10/13/14 revealed diagnoses included congestive heart failure, essential hypertension, osteoporosis, asthma, hypercholesterolemia, muscle weakness, difficulty walking, and closed fracture of three ribs. Review of Resident #1's assessment and care plan dated 05/29/15 revealed: - She required extensive assistance with toileting, dressing, and transferring.	D 273		

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D 273	Continued From page 1 - She required limited assistance with bathing and grooming. Review of Resident Log (RL) and Shift Report (SR) notes for Resident #1 revealed: - 06/01/15 (11:30 a.m.) (RL): Resident observed lying on floor in room. Resident has medium size skin tear on left wrist and 2 small skin tears on left lower leg. All areas cleaned and dressed. Faxed physician and notified responsible party, executive director (ED), and HWD. - 06/07/15 (5:00 a.m.) (RL, SR): Dressing on skin tears got changed last night. Resident said her leg was hurting last night. - 06/14/15 (4:00 a.m.) (RL): Resident had some swelling and pain in her leg. Redressed her leg with looser dressing. - 06/17/15 (11:30 a.m.) (RL): Skin tear on left wrist looks good. Two skin tears on left leg area are red. Will continue to monitor. - 06/20/15 (7am - 7pm) (SR): Skin tears looks good on hand. Leg needs to be looked at. [SR was signed at bottom for review by Executive Director (ED) and Health and Wellness Director (HWD)]. - 06/21/15 (7am - 7pm) (SR): Changed dressing on leg. Nurse need to look at leg. (SR was signed by ED and HWD). - 06/23/15 (9:15 a.m.) (RL): HWD documented left leg skin tear draining moderate amount of purulent / serosanguineous fluid periwound. Skin is red and edematous. Both lower extremities with 1+ pitting edema. Requested an order for wound clinic from primary physician's office. - 06/23/15 (3:20 p.m.) (RL): Received order for resident to be seen at urgent care to have leg evaluated. - 06/23/15 (4:00 p.m.) (RL): Received new order for Keflex 500mg every 8 hours until gone. (Keflex is an antibiotic for infection.)	D 273		

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D 273	Continued From page 2 Interview with a medication aide on 08/20/15 at 10:35 a.m. revealed: - The resident had a wound on her leg that "got bad" in June 2015. - The medication aides were very concerned about the resident's legs and it was brought to the HWD's attention more than once. - It got so bad the nurse "finally" looked at it. Interview with a second medication aide on 08/20/15 at 4:12 p.m. revealed: - The resident's legs were chronically swollen but were swollen more some days than others. - Staff documented and notified the HWD about the redness and swelling in the resident's legs in 06/2015. - She did not observe the HWD to look at the resident's legs when the HWD was notified of the condition of the resident's legs. - The HWD eventually made the resident a physician's appointment but she could not recall the date. Interview with the Health and Wellness Director / Registered Nurse (HWD) on 08/21/15 at 2:30 p.m. revealed: - She was in training in 06/2015 and not in the facility every day. - During that time, it may take her 3 to 7 days to review the shift notes and follow-up any concerns. - About 3 to 4 weeks ago, she started reviewing the shift notes and signing them daily. Interview with the Executive Director (ED) on 08/20/15 at 6:25 p.m. revealed: - Staff were supposed to notify the HWD of any changes in a resident's condition. - Staff should document it in the shift report and in the resident's record.	D 273		

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D 273	Continued From page 3 - If the HWD is not available, they have an on-call nurse available for advice. - HWD is responsible for following up any reports of changes in a resident's condition. Review of a physician's visit form dated 06/23/15 revealed: - The resident presented with a wound to her left lower leg which occurred after a fall a few weeks ago. - She is having increased redness and pain around it. - There are 2 wounds over the distal anterolateral aspect. - The resident has chronic lower extremity edema and has 2 - 3+ pitting edema with a very slight erythematous hue to the skin from the mid tibial area to the ankle. - The resident was diagnosed with lower leg wound with cellulitis and the wounds were debrided. - The wound will be hard to heal with the edema and she may need to be sent to wound care clinic. - The resident received antibiotic via injection and order for antibiotic to take by mouth. Review of a physician's visit form dated 06/24/15: - The resident was given another antibiotic injection for lower leg wound with cellulitis. - Left leg has 2cm in diameter ulcerative lesion in left lower leg with at least a 5cm zone of surrounding erythema (redness). - Wound was caused by previous trauma to the left pretibial area with secondary infection. Review of a physician's visit form dated 06/25/15 revealed resident was seen for lower leg wound with cellulitis and daily wet to dry dressings were ordered.	D 273		

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D 273	Continued From page 4 Review of a physician's visit form dated 06/30/15 revealed resident was seen for follow-up for lower leg wound with cellulitis and wound clinic consult was ordered. Review of Resident Log (RL) and Shift Report (SR) notes for Resident #1 revealed: - 06/25/15 (SR): Leg is red and warm. - 06/28/15 (SR): Leg area red. - 06/26/15 (SR): Seen by home health nurse. - 07/09/15 (RL): Resident went to appointment to have wound looked at. - 07/18/15 (RL): Resident's legs looking much better. Swelling has gone down. - 07/19/15 (7am - 7pm) (SR): Resident's legs have went down a lot. - 08/13/15 (RL): Resident received order to be discharged from the wound clinic but continue wearing stockings. Review of Resident #1's record revealed she was seen at the wound clinic on 07/09/15, 07/16/15, 07/23/15, 07/30/15, 08/06/15, and 08/13/15 (discharged due to wound healed). Review of Resident Log (RL) and Shift Report (SR) notes for Resident #1 revealed: - 08/16/15 (11:00 p.m.) (RL): While making rounds, staff noticed resident's left leg was swollen "real bad" down around ankle. There is a red band all the way around with blisters, some have popped and there is some weeping. Called on-call nurse and was told to send resident to the emergency room. - 08/17/15 (4:15 a.m.) (RL): Resident returned to facility. Resident is to follow-up with primary physician in 2 to 3 days. No other orders. Review of a hospital emergency room form dated	D 273		

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D 273	Continued From page 5 08/16/15 for Resident #1 revealed: - Resident was seen for left leg swelling and pedal edema. - Resident was discharged on 08/17/15 and was to follow-up with primary physician in 2 to 3 days. Record review revealed no documentation of a follow-up appointment being scheduled for Resident #1 after the emergency room visit on 08/16/15 - 08/17/15. Review of Resident Log (RL) and Shift Report (SR) notes for Resident #1 revealed: - 08/17/15 (11:00 a.m.) (RL): HWD documented resident's left lower extremity was red and weeping. Compression hose applied. Encourage resident to elevate legs as frequent as possible. Will call physician to schedule follow-up. - 08/18/15 (8:00 p.m.) (RL): Resident came and asked staff to remove her compression hose. Removed and left leg was swollen, red, and hose were wet from her leg weeping. - 08/19/15 (5:00 a.m.) (RL): Resident had no complaints concerning swelling. - 08/19/15 (7am - 7pm) (SR): Legs still weeping and swollen, blisters, swollen leg, and red band. Observation of Resident #1 on 08/19/15 at 11:38 a.m. revealed: - The resident was in her room sitting in motorized chair. - The resident was wearing knee high panty hose on both legs and white ankle socks on both feet. - The panty hose on her left leg a dark brown wet stain about 5 inches by 6 inches on the front of her shin area going down her leg. - The top of the white ankle sock had brown stains around the top of the sock. - Both of the resident's ankles were swollen.	D 273		

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D 273	Continued From page 6 Interview with Resident #1 on 08/19/15 at 11:38 a.m. revealed: - The resident had some other stockings that were being washed. - She had been going to the wound clinic because she had cellulitis but she did not go anymore. - She was not sure how long her leg had been draining but she stated it was not being dressed anymore. - She usually had swelling in both legs some days more than others. Interview with the HWD on 08/19/15 at 5:40 p.m. revealed: - Resident #1 had recently been discharged from the wound clinic because her leg wound had healed. - Her left leg started weeping and swelling over the weekend. - The resident was sent to the emergency room and received no new orders. - She observed Resident #1's left leg weeping yesterday. - She did not know if the follow-up appointment with the primary physician from the ER visit on 08/16/15 had been made. - The residents' legs were chronically swollen. - She had not seen the resident's legs today and did not realize they were still weeping. - She did not know if the physician was aware the resident's leg was currently weeping and swollen. Observation of Resident #1 on 08/20/15 at 8:10 a.m. revealed: - Resident #1 was coming out of the dining room in her motorized wheel chair. - Resident was wearing compression stockings on both legs.	D 273		

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D 273	Continued From page 7 - The compression stocking on her left leg was wet and had a drainage stain about 4 inches by 5 inches on the front of her shin area. - There was a large band aid placed the top of her left shin that was underneath the hose in the area where the drainage was noted. - Both ankles were swollen. Interview of Resident #1 on 08/20/15 at 8:10 a.m. revealed: - Resident #1 was waiting to go to a dental appointment. - She denied any pain in legs. Interview with a medication aide on 08/20/15 at 10:35 a.m. revealed: - The resident's leg had gotten better over the last couple of weeks. - She saw drainage from the resident's left leg again yesterday. - She was unsure how long it had been draining again. - The resident usually wears TED hose. - The resident's ankles are both usually swollen but she thought the swelling was worse when she saw it yesterday. - The resident had not complained about leg pain to her. - She did not know if the physician had been contacted. Telephone interview with the Licensed Practical Nurse (LPN) at Resident #1's primary physician's office on 08/20/15 at 10:20 a.m. revealed the facility just contacted their office that morning on 08/20/15 and made an appointment for 10:20 a.m. on 08/20/15 to be seen due to swelling in legs. Telephone interview with the nurse from the	D 273		

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D 273	Continued From page 8 wound clinic on 08/20/15 at 3:10 p.m. revealed: - Resident #1 was referred to the wound clinic on 06/30/15 and her initial visit was on 07/09/15. - When the resident was first seen at the wound clinic, she had weeping blisters on her left leg. - The resident's legs were chronically swollen but they were able to get them down to baseline prior to her discharge from the wound clinic on 08/13/15. - They had not been notified that the resident's leg was currently weeping again. Interview with the Resident Care Coordinator (RCC) on 08/20/15 at 4:30 p.m. revealed: - Shift reports are reviewed by the HWD and the ED. - The HWD would do any skin assessments. - Staff had not reported any concerns about Resident #1's condition to her. - Changes in a resident's condition should be reported to the HWD or the on-call nurse if the HWD was unavailable. Interview with the ED on 08/20/15 at 4:35 p.m. revealed: - She and the HWD usually reviewed shift reports the next morning. - She usually checked to make sure any reportable incident reports had been completed. - The HWD was responsible for following up on any incidents. - Staff should report concerns or changes in condition to the HWD. - If the HWD was unavailable, staff should contact the on-call nurse for advice or they could also contact the HWD via phone if needed. - Staff should document contacts with the nurse. Review of a primary physician's visit form dated 08/20/15 for Resident #1 revealed:	D 273		

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D 273	Continued From page 9 - Resident was seen for follow-up for left leg redness/weeping. - Physician noted resident has chronic edema - no worse than usual; has ulcer upper anterior tibial area and lower anterior tibial area. - Physician wrote an order to try large band aids to upper and lower ulcers and change as needed. - Physician wrote order to increase Lasix to 20mg daily and 40mg daily on Mondays, Wednesdays, and Fridays and follow-up in 2 weeks. Observation of Resident #1 on 08/21/15 at 9:15 a.m. revealed: - The resident was wearing TED hose and both of her lower extremities were swollen. - There was an area of dark brown wet drainage stained on the TED hose on her left leg on the shin area. Interview with Resident #1 on 08/21/15 at 9:15 a.m. revealed the resident denied any current symptoms of pain. Interview with the HWD on 08/21/15 at 11:00 a.m. revealed: - They were currently working on a system for referrals. - Medication aides are responsible setting up appointments and documenting in the tracking book. - They just started a notebook, calendar, and log sheet about 3 weeks ago to try to track appointments. B. Review of skin observation forms for Resident #1 revealed: - 05/12/15 - resident's left arm was "very dry". - 08/06/15 - resident's left arm and right arm had	D 273		

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D 273	Continued From page 10 excessive dryness/flaking. Review of a visit form dated 08/13/15 from the wound clinic for Resident #1 revealed: - Resident was being discharged from wound clinic because wound on left leg was healed. - Order to follow up with dermatology for left arm and hand. Review of Resident #1's record revealed no documentation the resident had been seen by a dermatologist or that an appointment had been made. Interview with the Health and Wellness Director / Registered Nurse (HWD) on 08/20/15 at 11:30 a.m. revealed: - She was unaware of the dermatology referral. - She would check to see if an appointment had been made. Interview of Resident #1 on 08/21/15 at 9:15 a.m. revealed: - The resident pointed to dry flaking skin and at least 4 "warts" on her left arm and hand. - She stated, "They (warts) annoy me". - She had not been to a dermatologist yet and there was no appointment made to her knowledge. - They were supposed to make a dermatology appointment over a week ago. - She did not know why facility staff had not made the appointment. Interview with the HWD on 08/21/15 at 11:00 a.m. revealed: - They were currently working on a system for referrals. - Medication aides were responsible setting up appointments and documenting in the tracking	D 273		

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D 273	Continued From page 11 book. - They just started a notebook, calendar, and log sheet about 3 weeks ago to try to track appointments. - She did not know why a dermatology appointment was not made for Resident #1. - She was aware the resident had dry skin on her hands. Interview with the HWD on 08/21/15 at 2:30 p.m. revealed: - Staff was supposed to make the dermatology appointment for Resident #1 yesterday after it was brought to their attention by surveyor. - She did not know why the appointment did not get made. - Staff tried to call and make the appointment today but the dermatology offices they called were closed. - They will have to wait until Monday, 08/24/15, to make the dermatology appointment. Review of a staff note on 08/21/15 revealed: - Facility staff called 3 dermatology offices but we unable to reach anyone due to the offices being closed on Fridays. - Staff noted they would call back on Monday, 08/24/15, to schedule a dermatology appointment for Resident #1. _____ Review of the facility's plan of protection dated 08/21/15 revealed: - Health & Wellness Director (HWD), Resident Care Coordinator (RCC), and designee will immediately begin an audit of resident records to assure changes of conditions have been communicated to primary care physician and follow-ups have been completed. - Floor staff will report changes of condition to	D 273		

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D 273	Continued From page 12 the medication aide, RCC, HWD, and/or designee. - Medication aide, RCC, HWD, and/or designee will report changes to the primary care physician and document in the Resident Log. - HWD, Executive Director (ED), and/or designee will review the shift report daily, sign, and date at the bottom. - HWD, RCC, and/or designee will document concerns in the Resident Log and follow up will be completed. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 20, 2015.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure documentation and implementation of physician's orders for 2 of 5 residents (#3, #4) sampled related to the two residents not wearing TED (thromboembolism deterrent) hose as ordered. The findings are:	D 276		

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D 276	Continued From page 13 1. Review of Resident #3's current FL-2 dated 08/13/14 revealed diagnoses included status post hip fracture, history of falls, hypertension, dysphagia, mild cognitive impairment, and cognitive communicate deficit. Review of a primary physician visit form dated 11/25/14 revealed an order that TED hose needs to be put on and taken off daily. Review of Resident #3's June 2015, July 2015, and August 2015 medication administration records revealed: - The order for TED hose was not included on the MARs. - There was no documentation to indicate the TED hose were being applied and removed as ordered. Review of Resident #3's August 2015 activities of daily (ADL) sheet revealed: - A handwritten entry with "TED hose on" beside the row for other tasks. - Staff had not initialed beside the row for TED hose for the entire month. - There was no documentation that the TED hose were applied. Review of the Licensed Health Professional Support (LHPS) review dated 08/06/15 for Resident #3 revealed: - The facility's Health and Wellness Director / Registered Nurse completed the review. - She documented Resident #3 had 1+ pitting edema (swelling) to bilateral lower extremities. - She noted the resident had TED hose ordered but he was non-compliant to use. - She noted the family and physician were aware. Interview and observation of Resident #3 on	D 276		

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D 276	Continued From page 14 08/21/15 at 9:02 a.m. revealed: - Resident #3 was not wearing TED hose. - His left ankle was slightly swollen. - He has TED hose in his room. - He wears them "once in a while" if his legs swell. - He was unable to put on the TED hose himself. - Staff did not offer to put on the TED hose. - He would let staff know when he needed to wear them. - He had not worn the TED hose in "a couple of months". Interview with the Health and Wellness Director / Registered Nurse (HWD) on 08/21/15 at 9:40 a.m. revealed: - She did not know if Resident #3 wore TED hose. - If there was an order for TED hose, it should be transcribed on the MARs. - Staff should be applying the TED hose and documenting it on the MARs. - She would contact the physician regarding the TED hose. Interview with a medication aide on 08/21/15 at 9:45 a.m. revealed: - Resident #3 has TED hose in his room. - She did not know why the TED hose were not listed on the MARs. - Resident #3 would require assistance by staff to put on the TED hose. - She had not seen Resident #3 wear TED hose in "months". - She did not know why the resident was not wearing the TED hose. Interview with a personal care aide (PCA) on 08/21/15 at 10:10 a.m. revealed: - She was assigned to provide care to Resident	D 276		

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D 276	Continued From page 15 #3 at least weekly. - The Activities of Daily Living form indicated Resident #3 needed to wear TED hose daily. - Sometimes Resident #3 refused to wear the TED hose. - She did not know how often the resident refused to wear the TED hose weekly. Interview with a second PCA on 08/21/15 at 10:14 a.m. revealed: - The PCA was assigned to work with Resident #3 twice weekly. - Resident #3 had been wearing TED hose for a couple of months. - The resident refused to wear the TED hose two to three times weekly. - When the resident refused to wear the TED hose, she informed the medication aide on duty. - Resident #3 was only supposed to wear the TED hose if the resident's legs were swollen. - She was assigned to provide care for Resident #3 the week of 08/16/15 to 08/21/15 and the resident legs did not look swollen. - The resident had not requested to wear the TED hose this week. Interview with the Resident Care Coordinator (RCC) on 08/21/15 at 10:54 a.m. revealed: - Resident #3 wore the TED hose when needed and not daily. - When Resident #3 first got the order to wear TED hose daily, the resident's responsible party only wanted the resident to wear the TED hose as needed (swelling). - Resident #3 had not had any problems with the legs being swollen to her knowledge. Interview with the HWD on 08/21/15 at 11:00 a.m. revealed: - Either the medication aides or the personal	D 276		

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D 276	Continued From page 16	D 276		

care aides can put on TED hose.
- The medication aides were supposed to check daily to make sure TED hose are being worn.
- After seeing the LHPS review, she now recalled and was aware Resident #3 was non-compliant with wearing his TED hose.
- She did not notify the physician.
- She had no explanation for not notifying the physician.
- She started working at the facility in April 2015 and she was not familiar with the ADL sheet.
- She did not know if staff was supposed to document the TED hose on the ADL sheet.

Interview with the Resident Care Coordinator (RCC) on 08/21/15 at 12:10 p.m. revealed:
- TED hose should be documented on the MARs.
- Staff would only documented on the ADL sheet if a resident refused the TED hose.
- She did not know Resident #3 was supposed to wear TED hose.

Telephone interview with the nurse at Resident #3's primary physician's office on 08/21/15 at 12:35 p.m. revealed:
- There was an order dated 11/25/14 to wear TED hose daily.
- There was no documentation in their files to indicate the resident refused to wear the TED hose.
- The physician documented no lower extremity edema during the resident's last two appointments on 03/31/15 and 07/07/15.
- The facility called the physician's office today, 08/21/15, to get the TED hose order changed to a "prn" (as needed) order.

Review of a prescription faxed by Resident #3's physician's office and dated 08/21/15 revealed an

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D 276	Continued From page 17 order to apply TED hose as needed per patient request. 2. Review of Resident #4's current FL-2 dated 11/24/14 revealed: -Diagnoses included hypertension, history of iron deficiency anemia, hypothyroidism, osteoporosis, diabetes mellitus, coronary artery disease, history of ST elevation myocardial infarction (STEMI/MI), history of stage 2 kidney disease, history of encephalopathy secondary to transient ischemic attack (TIA). -Physician order for TED hose (thromboembolic disease hose) on 24 hours. Review of Resident 4's record revealed physician order sheet dated 07/08/15 signed by prescribing provider for TED hose on 24 hours. Review of the Resident Daily Log sheets revealed: -Documentation dated 02/26/15 on the Resident Daily Log that Resident #4's Primary Care Provider(PCP) was contacted because she had 4+ edema to her bilateral lower extremities. -On 02/26/15, the PCP gave new orders to increase Resident #4's diuretic medications and assess daily weights. Observation of Resident #4 at 10:17 a.m. on 08/20/15 revealed: -Resident #4 was sitting in the gallery room of the facility. -Resident had her walker at her chairside. -Resident was not wearing TED hose. Observation and interview with Resident #4 at 12:55 p.m. on 08/20/15 revealed: -Resident #4 was alert and oriented. -Resident was not wearing TED hose.	D 276		

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D 276	Continued From page 18 -Resident #4 said she wore TED hose "from time to time." -"I wear them if my legs are swelling." -Facility staff assisted her to put on and remove her TED hose as needed. -"I get Lasix twice a day for leg swelling." -Resident had a foam cushion to elevate her lower extremities at night. -Resident #4 elevated her lower extremities more when she had swelling. Observation of Resident #4's July 2015 MARs revealed: -Entry for TED hose on 24 hours with administration times handwritten as "7A-7P" and "7P-7A." -There were staff initials written beside the TED hose entry for "7A-7P" and "7P-7A" for each date between July 1 and July 31. -There was no documentation Resident #4 refused TED hose on the MAR. Observation of Resident #4's August 2015 MARs revealed: - Entry for TED hose on 24 hours with administration times handwritten as "7a-7p" and "7p-7a." -There were staff initials written beside the TED hose entry for "7A-7P" and "7P-7A" for each date between August 1 and August 19. -There were check marks written below the staff initials beside the TED hose entry for "7A-7P" and "7P-7A"." -There were no check marks documented on the MAR beside "7A-7P" on August 12 and August 19. -There were no check marks documented on the MAR beside "7P-7A" on August 6, August 7, August 12, August 13, August 18, and August 19. -There was no documentation of Resident #4	D 276		

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D 276	Continued From page 19 refusing TED hose on the MAR. Interview with the MA at 3:50 p.m. on 08/20/15 revealed: -Resident #4 had an order for TED hose on her MARs. -Resident #4 does not wear her TED hose "sometimes." -Resident Care Assistants (RCAs) are responsible for assisting residents with TED hose. -The MAs initial the MARs as documentation the resident was wearing the TED hose. -The RCAs communicates that residents were wearing TEDs to the MA. -The MAs "can see the TEDs are on the resident." -The check marks documented on Resident #4's August 2015 MARs indicate the RCA put the TEDs on the resident. -The dates and times with no check mark on Resident #4's August 2015 MAR meant the TED hose were not on the resident. -The MAs are responsible for documenting a resident's refusal of ordered treatments the on the resident's MAR. -It was facility procedure for the MA to document a resident's refusal to wear TED hose on the back of the resident's MARs. -When a resident refused TED hose, the MA was supposed to notify the Resident Care Coordinator (RCC), Health and Wellness Director (HWD), and resident's physician of the refusal. -If a resident continues to refuse TED hose, the facility "sometimes" attempts to get a physician order to discontinue the TED hose. Interview with the RCC at 12:35 p.m. on 08/19/15 revealed: -Resident #4 had a physician's order for TED	D 276		

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D 276	Continued From page 20 hose. -The RCC could not recall if Resident #4 required staff assistance with applying and removing her TED hose. Interview with the RCC at 4:50 p.m. on 08/20/15 revealed: -Resident #4 did not always wear her TED hose per the physician orders. -MAs and RCAs are responsible for ensuring residents TEDs are put on. -The MAs can delegate the responsibility of application of resident's TED hose to RCAs. -Refusal of TED hose is documented in the resident record and on the back of the resident's MAR. -The prescribing provider should be notified of the refusal by fax "to see if they can be discontinued." -The MAs are responsible for all documentation related to refusal of TED hose. -The MAs, RCC, or HWD are responsible for notifying the prescribing provider. -The check marks documented on Resident #4's August MARs "means done on the MARs." Interview with the Health and Wellness Director/Registered Nurse (HWD/RN) at 10:35 a.m. on 08/21/15 revealed: -MAs are responsible for ensuring residents wear TED hose per order of prescribing provider. -TED hose orders are transcribed to the MARs. -The HWD/RN expects refusals for TED hose to be documented using the same process for documenting medication refusals. -Refusal of medication and treatments are documented by the MAs. -The MAs write and circle their initials beside the corresponding MAR entry and "flip it over on the back" to document the reason for refusal. -The MAs are supposed to notify the HWD/RN,	D 276		

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D 276	Continued From page 21 and resident's physician and responsible party of refusals. -It was facility procedure for the MAs to notify the HWD/RN of medication and treatment refusals by documenting on the shift report. -THE HWD/RN did not know if Resident #4's PCP was aware she was not wearing her TED hose as ordered. Interview with the Executive Director (ED) at 3:40 p.m. on 08/20/15 revealed: -It was facility procedure for the MA staff to initial the MARs and circle the initialed entry to document a medication or treatment as not given. -It was facility procedure to "document the reason for the exception on the back of the MAR." -The MA who is working that shift and giving medication is responsible for documenting medications and treatments as administered or refused on the resident's MAR. -The MAs are expected to notify the HWD/RN or RCC when a resident refuses medications and treatments. Telephone interview with Resident #4's primary care physician (PCP) at 8:55 a.m. on 08/21/15 revealed: -Resident #4 had been in congestive heart failure (CHF) and had edema in her lower extremities when the TED hose order was originally written. -Resident #4's health status had improved and it was ok for her not to wear the TED hose 24 hours a day. -The PCP had last evaluated Resident #4 on 08/20/15 and she was "doing well." -The PCP could not recall the facility staff contacting him for notification that Resident 4 was not wearing her TED hose per orders. -He would clarify the TED hose order to indicate Resident #4 wear the TED hose PRN (as	D 276		

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D 276	Continued From page 22 needed).	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 2 of 14 residents (#1, #6) observed during the medication passes, including errors with an antibiotic for a dental procedure, an antibiotic eye ointment, and topical gel for pain and inflammation and 2 of 5 residents (#1, #5) sampled for review related to errors with pain medication, a diuretic for swelling, a potassium supplement, and topical antibiotic ointments. The findings are: 1. The medication error rate was 11% as evidenced by the observation of 3 errors out of 26 opportunities during the 8:00 a.m., 11:30 a.m./12:00 p.m., and the 4:00 p.m. medication passes on 08/20/15. A. Review of Resident #1's current FL-2 dated	D 358		

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D 358	Continued From page 23 10/13/14 revealed diagnoses included muscle weakness, unspecified essential hypertension, difficulty walking, pure hypercholesterolemia, unspecified osteoporosis, and congestive heart failure (CHF) "unspecified." Review of Resident #1's record revealed: -Signed physician order sheet dated 07/08/15 for Voltaren 1% gel, apply 2 grams to each hand three times daily. (Voltaren 1% gel is a medication used relieve pain from osteoarthritis in certain joints such as those of the knees, ankles, feet, elbows, wrists, and hands). Observation of the medication pass at 1:13 p.m. on 08/20/15 revealed: -Resident #1 was alert and oriented and sitting in her electric wheelchair. -The Medication Aide (MA) squeezed a small amount of Voltaren gel into a clear, plastic, graduated medication cup and then applied and rubbed the gel into both of Resident #1's hands. -The MA did not measure the Voltaren gel before administering the medication to the Resident. -Resident #1 stated "Is this new?" -The MA replied to Resident #1 that she had been refusing the medication. -Resident #1 denied refusing the medication. Interview with Resident #1 at 1:18 p.m. on 08/20/15 revealed: -"I don't know about the cream. I'm surprised." -The resident asked if her physician had recommended the medication. -Resident #1 did not remember refusing the medication; "If I did, it was a long time ago." -"I don't remember refusing anything." -Resident #1 denied pain in her hands at that time. -Resident #1 said her hands "hurt sometimes."	D 358		

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D 358	Continued From page 24 Interview with a MA at 8:10 a.m. on 08/20/15 revealed: -The MAs initial the resident's Medication Administration Records (MARs) beside each medication or treatment entry for the corresponding date and time to document the medication or treatment had been administered. -The MAs write and circle their initials on the MARs as documentation a medication was not administered and document the reason it was not administered on the reverse side of the MAR. Review of Resident #1's August 2015 MARs revealed: -Entry for "Voltaren Gel 1%, Apply 2 gm to each hand three times a day max 32 gm total/day to all affected joints, external use only" with scheduled dosing times of 08:00 a.m., 12:00 p.m., and 8:00 p.m. -There were staff initials written beside the Voltaren gel entry documenting the medication was administered to Resident #1 at the scheduled times from 08/01/15 through 08/20/15. -None of the staff initials documented beside the Voltaren gel entry were circled. -There was no documentation on Resident #1's MARs that indicated Voltaren gel was refused and not administered. Interview with the MA at 5:20 p.m. on 08/201/5 about the Voltaren gel revealed: -The pharmacy had told the MA staff to put the Voltaren gel in a cup for administration. -"We don't have a way to measure it really." Observation of the medications in the medication cart for Resident #1 at 5:22 p.m. on 08/20/15 revealed: -The graduated cup that the MA squeezed the	D 358		

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D 358	Continued From page 25 Voltaren gel into prior to administration did not have the appropriated markings for measurement of grams. -One tube of Voltaren 1% Gel with a dispense date of 07/08/15 with directions to apply 2 grams to each hand three times daily with a maximum dose of 32 grams daily to all affected joints. -The tube of Voltaren gel was 2/3 full. -Inside the Voltaren Gel box there was a reusable manufactured approved measuring device which included indications for measurement of 2 grams and 4 grams of the medication. -The MA was unaware of the measuring device in the box Interview with the Health and Wellness Director/Registered Nurse (HWD/RN) at 10:35 a.m. on 08/21/15 revealed: -The MAs write and circle their initials beside the corresponding MAR entry as documentation a medication or treatment was refused and "flip it over on the back" to document the reason for refusal. -The MAs are supposed to notify the HWD/RN, and resident's physician and responsible party of refusals. -The HWD/RN had no knowledge of Resident #1 refusing Voltaren gel. -Resident #1 had only complained of dry skin on her hands and not complained of pain in her hands. -MAs have been trained to measure liquid, cream, and gel medications. -The Voltaren gel should have been measured with the supplied measuring device. B. Review of Resident #6's current FL-2 dated revealed diagnoses included atrial fibrillation, hypertension, congestive heart failure, mitral valve prolapse, and chronic lower extremity	D 358		

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D 358	Continued From page 26 edema. Review of Resident #6's record revealed: -Documentation on the "Physician Visit Form" dated 08/11/15 that Resident #6 was evaluated by a physician. -The findings documented on the Physician Visit Form included chalazion right lower lid. (A chalazion is a small bump in the eyelid caused by a blockage of a tiny oil gland). -Signed physician order on the Physician Visit Form for "warm compresses 3 minutes 3 times daily followed by Tobradex ointment for 3 weeks." (Tobradex ointment is a combination of the medications Tobramycin and Dexamethasone used to treat swelling, redness, and infections of the eye). -The physician order dated 08/11/15 did not specify which eye to administer the Tobradex ointment. -There were no additional physician orders which clarified which eye to administer the Tobradex ointment. Observation of the medication pass at 08:28 a.m. on 08/20/15 revealed: -The MA applied Tobradex ointment to Resident #6's right and left eye lids with a cotton tipped applicator. -Resident #6 told the MA she had done a warm compress about 10 minutes before. Review of Resident #6's August 2015 Medication Administration Records (MARs) revealed a hand written entry "Apply warm compresses 3 min. three times daily followed by Tobradex ointment R eyelid for 3 weeks" with scheduled dosing times of 8:00 a.m., 2:00 p.m., and 7:00 p.m. Observation and interview with Resident #6 at	D 358		

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D 358	Continued From page 27 10:30 a.m. on 08/21/15 revealed: -Resident was alert and oriented. -Resident #6 had been receiving treatment on her right eye for 11 days. -Resident #6 saw the eye doctor for a "stye" on her right eye and "the very next day it came up on my left eye." -Before yesterday (08/20/15), the facility had been treating both her right and left eyes with Tobradex ointment "because I ask her to." -"I've been doing the compresses on both eyes too." -Resident #6 was told by the MA on 08/20/15 that she couldn't treat both of her eye lids anymore because there was not a physician order. -Resident #6 had called her eye doctor on 08/20/15 "to straighten it out. I did not understand because they had been doing it until yesterday." -The office told the resident the Tobradex order would be changed for administration to both eye lids. -Resident #6 said the Registered Nurse (RN) had looked at her left eye "one day when I was putting a compress to it" but "she did not mention anything about not putting it in both eyes to me. The Med Tech told me yesterday." -The resident said the incident had been "very stressful" for her. Interview with the MA at 11:05 a.m. on 08/21/15 revealed: -Resident #6 had asked the MAs to apply Tobradex ointment to both of her eye lids. -Staff had been putting Tobradex ointment of both of Resident #6's eye lids "starting over the weekend." -MA staff should have gotten the Tobradex ointment order clarified when Resident #6 requested that staff put it on both of her eye lids. -The order had been clarified on 08/20/15.	D 358		

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D 358	Continued From page 28 Interview with the HWD/RN at 10:35 a.m. on 08/21/15 revealed: -Resident #6 went to the eye doctor about "a week and a half ago" for a chalazion on her right eye. -The MA had told the HWD/RN the previous day that Resident #6 wanted Tobradex ointment applied to both of her eye lids. -The MA told the HWD/RN she had applied Tobradex ointment to both of Resident #6's eye lids. Telephone interview with the Ophthalmology Technician at 10:15 on 08/21/15 revealed: -The office was not notified that Resident #6 had a chalazion on her left eyelid until the day before when the "patient called the office herself to report the condition." -Resident #6 called the ophthalmology office at 11:30 a.m. on 08/20/15 to ask if Tobradex could be used on both her right and left eyes. -The physician order dated 08/11/15 was expected for Tobradex ointment to be applied to Resident #6's right eye lid only because the resident did not have the condition on the left eye when evaluated by the physician. -The physician order dated 08/20/15 for Tobradex ointment was changed after Resident #6 called the office requesting the order be changed for application to both eye lids. Record review revealed a signed physician order dated 08/20/15 for Tobradex ointment apply to both eyes after warm compress as needed for 2 weeks for chalazion. C. Review of Resident #1's current FL-2 dated 10/13/14 revealed diagnoses included congestive heart failure, essential hypertension,	D 358		

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D 358	Continued From page 29 osteoporosis, asthma, hypercholesterolemia, muscle weakness, difficulty walking, and closed fracture of three ribs. Observation and interview of Resident #1 on 08/20/15 at 8:10 a.m. revealed: - The resident was sitting in her motorized chair in the common living area near the front door. - She had a dentist appointment that morning and was waiting to be transported to the dentist office. Review of a physician's order dated 03/25/15 revealed: - Antibiotic prophylaxis was required prior to dental visits. - Order to take Amoxicillin 500mg 4 capsules (2 grams) 1 hour prior to appointment. (Amoxicillin is an antibiotic for infection.) Review of a Resident Log note dated 06/04/15 revealed Resident #1 had a follow-up dentist appointment scheduled for 08/20/15 at 9:45 a.m. Review of the August 2015 medication administration record (MAR) revealed: - Entry for Amoxicillin 500mg take 4 by mouth 1 hour prior to dental appointment. - The entry was bland with no documentation of any Amoxicillin being administered for August 2015. Interview with the medication aide on 08/20/15 at 8:40 a.m. revealed: - She had already completed the morning medication pass. - Resident #1 was waiting at the door because she had a dentist appointment scheduled for today, 08/20/15, at 9:45 a.m. - She had not administered any Amoxicillin to	D 358		

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D 358	Continued From page 30 Resident #1 that morning. - She looked at the August 2015 MAR and stated she did not notice the Amoxicillin needed to be administered because today's date was not blocked off. - She reported when the appointments were made staff was supposed to block off the appointment date on the MAR so they would know when to give the dose. - She checked the appointment book again and stated the dental appointment was at 9:45 a.m. - She would give the Amoxicillin to the resident now since she had not left for her dental appointment yet. Observation on 08/20/15 revealed the medication aide administered 4 capsules of Amoxicillin 500mg to Resident #1 at 8:44 a.m. Interview with the Health and Wellness Director / Registered Nurse (HWD) on 08/20/15 at 9:45 a.m. revealed: - The Amoxicillin for the dental appointment should be blocked off on the MAR at the time the appointment was made to flag staff to give the medication. - Staff had been trained to read the MARs and should have seen the order on the MARs for the Amoxicillin. - Resident #1's dental appointment was cancelled this morning so the resident could be seen by her primary physician for concerns with her leg. - She was not sure if the medication aide was informed the dentist appointment had been cancelled. 2. Review of Resident #1's current FL-2 dated 10/13/14 revealed diagnoses included congestive	D 358		

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D 358	Continued From page 31 heart failure, essential hypertension, osteoporosis, asthma, hypercholesterolemia, muscle weakness, difficulty walking, and closed fracture of three ribs. A. Review of Resident #1's current FL-2 dated 10/13/14 revealed an order for Lasix 20mg once daily. (Lasix is a diuretic used to treat swelling.) Review of a prescription dated 11/04/14 for Resident #1 revealed an order for Lasix 20mg take 1 tablet once daily as needed for extra swelling in addition to Lasix 20mg once daily. Review of an electronic prescription written on 07/09/15 revealed: - Order for Potassium Chloride 10mEq 1 tablet once daily. (Potassium Chloride is a supplement used to treat and prevent low potassium levels.) - The prescription was electronically sent to the pharmacy and received by the pharmacy on 07/09/15. - Fax stamp date at top of page indicated pharmacy faxed a copy of the prescription to the facility on 07/19/15. Review of a Resident Log note dated 07/10/15 revealed: - HWD spoke with nurse at Resident #1's physician's office. - The nurse told the HWD that Resident #1's Lasix had been doubled for 7 days and Potassium was added. - HWD requested an order be faxed to the facility. Record review revealed no order to double Lasix for 7 days. Review of the July 2015 and August 2015	D 358		

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medication administration records (MARs) revealed:
- Lasix 20mg once daily was documented as administered daily from 06/01/15 - 08/20/15.
- Entry for Lasix 20mg once daily as needed for extra swelling.
- No documentation of any prn (as needed) Lasix being administered to the resident from 06/01/15 - 08/20/15.
- No entry for the scheduled Lasix dose to be doubled for 1 week in July 2015.
- Handwritten entry dated 07/19/15 for Potassium 10mEq 1 tablet daily with scheduled time of 8:00 a.m.
- Potassium was documented as administered from 07/20/15 - 08/20/15 for a total of 32 doses.
- No documentation of any missed doses during this 32 day time period.

Review of medications on hand on 08/20/15 at 10:50 a.m. revealed:
- One supply of 30 tablets of Potassium Chloride 10mEq were dispensed on 07/09/15.
- 10 of the 30 Potassium Chloride tablets remained on hand.
- One 3 month supply of Lasix 20mg once daily was dispensed by the veteran's pharmacy on 05/27/15.

Interview with a medication aide on 08/20/15 at 10:50 a.m. revealed:
- The resident usually took the Potassium to her knowledge.
- The resident did not usually refuse medications.
- She did not recall having another supply of Potassium from any other pharmacy.

Interview with a second medication aide on 08/20/15 at 4:12 p.m. revealed:
- The resident's legs were chronically swollen but

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D 358	Continued From page 33 were swollen more some days than others. - She has never administered the extra prn Lasix. - She would not give the extra Lasix unless the resident went to a physician's visit and came back with a specific order to give it that day. - Staff documented and notified the HWD about the redness and swelling in the resident's legs. Interview with a third medication aide on 08/20/15 at 10:35 a.m. revealed: - She saw drainage from the resident's left leg again yesterday. - The resident usually wears TED hose. - The resident's ankles are both usually swollen but she thought the swelling was worse when she saw it yesterday. - She had never given the extra Lasix because the resident would let them know if something was bothering her. - It was hard to tell when to give the extra Lasix. - The resident had not complained about leg pain to her. Interview with a pharmacy technician at a local independent pharmacy on 08/20/15 at 9:28 a.m. revealed: - They had not dispensed any medications to Resident #1 since 2014. - The pharmacy received an electronic prescription for Potassium Chloride 10mEq once daily for Resident #1 on 07/09/15. - They filled the prescription on the same day 07/09/15. - The Potassium was placed in the bin at the pharmacy to be picked up per routine. - The pharmacy received a call on 07/18/15 at 5:37 p.m. for the medication to be delivered to the facility. - She did not know who called the pharmacy to	D 358		

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request delivery.
- The Potassium would probably have been delivered the next day on 07/19/15 due to the time of the request.
- She did not see an order for Lasix for Resident #1.
- They never dispensed any Lasix for Resident #1.

Review of pharmacy dispensing records dated 02/22/15 - 08/20/15 from the primary pharmacy revealed no Potassium had been dispensed by this pharmacy for Resident #1.

Review of Resident Log (RL) and Shift Report (SR) notes for Resident #1 revealed:
- 06/14/15 (4:00 a.m.) (RL): Resident had some swelling and pain in her leg.
- 06/23/15 (9:15 a.m.) (RL): HWD documented left leg skin tear draining moderate amount of purulent / serosanguineous fluid periwound. Skin is red and edematous. Both lower extremities with 1+ pitting edema.
- 06/23/15 (3:20 p.m.) (RL): Received order for resident to be seen at urgent care to have leg evaluated.
- 06/23/15 (4:00 p.m.) (RL): Received new order for Keflex 500mg every 8 hours until gone. (Keflex is an antibiotic for infection.)
- 07/18/15 (RL): Resident ' s legs looking much better. Swelling has gone down.
- 07/19/15 (7am - 7pm) (SR): Resident's legs have went down a lot.
- 07/20/15 (SR): New order for Potassium. Started Potassium this morning.
- 08/16/15 (11:00 p.m.) (RL): While making rounds, staff noticed resident's left leg was swollen "real bad" down around ankle. There is a red band all the way around with blisters, some have popped and there is some weeping. Called

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D 358	Continued From page 35 on -call nurse and was told to send resident to the emergency room. - 08/17/15 (4:15 a.m.) (RL): Resident returned to facility. Resident is to follow-up with primary physician in 2 to 3 days. No other orders. - 08/17/15 (11:00 a.m.) (RL): HWD documented resident's left lower extremity was red and weeping. Compression hose applied. Encourage resident to elevate legs as frequent as possible. Will call physician to schedule follow-up. - 08/18/15 (8:00 p.m.) (RL): Resident came and asked staff to remove her compression hose. Removed and left leg was swollen, red, and hose were wet from her leg weeping. - 08/19/15 (5:00 a.m.) (RL): Resident had no complaints concerning swelling. - 08/19/15 (7am - 7pm) (SR): Legs still weeping and swollen, blisters, swollen leg, and red band. Telephone interviews with the Licensed Practical Nurse (LPN) at Resident #1's primary physician's office on 08/20/15 at 10:20 a.m. and 08/21/15 at 12:35 p.m. revealed: - They received a call from the facility's former Health and Wellness Director / Registered Nurse (HWD) in November 2014. - The former HWD indicated the resident had extra swelling in her legs at that time in November 2014. - The physician wrote an order for Lasix 20mg once daily as needed for extra swelling in November 2014. - They received a call from the wound clinic on 07/09/15 about the resident's legs being swollen. - She called the facility and spoke with the current HWD on 07/09/15. - She asked if the resident had received any of the prn (as needed) Lasix. - She was told the facility staff could not assess the resident and could not give the prn Lasix.	D 358		

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D 358	Continued From page 36 - She called in a verbal order to increase the Lasix to 20mg take 2 tablets daily in the morning for 7 days (call doctor's nurse with an update on swelling) and add Potassium Chloride 10mEq once daily. - They added Potassium to prevent the resident's potassium level from dropping due to the extra Lasix. - The HWD told her she could not take a verbal order and needed written orders. - She faxed a prescription for the Lasix and Potassium to the facility on 07/09/15. - They do not get fax confirmation but they will get a fax printout of a failure confirmation if the fax does not to go through. - She did not receive a failure confirmation for the fax that was sent to the facility on 07/09/15. - She sent an electronic prescription for the Potassium to the local independent pharmacy listed on the resident's file on the same day, 07/09/15. - She did not send a prescription for the Lasix to the pharmacy since the resident already had this medication on hand at the facility. - She discussed with the HWD that she would not send a prescription to the pharmacy for the Lasix since the resident already had Lasix on hand. - She did not receive any further calls from the facility after 07/09/15 to her knowledge. - The HWD did not contact her supervisor to her knowledge. - The facility never called with an update on the resident's swelling as indicated in the order dated 07/09/15. - The facility just contacted their office on the morning of 08/20/15 and made an appointment for 10:20 a.m. on 08/20/15 to be seen due to swelling in legs. - The resident's Potassium level was checked on	D 358		

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D 358	Continued From page 37 08/20/15 and was 5.0 (within normal range). Review of prescriptions faxed by the primary physician's office on 08/20/15 revealed: - Prescription dated 07/09/15 for Lasix 20mg take 2 tablets every morning for 7 days then call doctor's nurse with update on swelling. - Prescription dated 07/09/15 for Potassium Chloride 10mEq take 1 tablet every day. Interview with the HWD on 08/21/15 at 11:00 a.m. revealed: - The Licensed Practical Nurse (LPN) from Resident #1's primary physician's office called about the resident's legs being very swollen and they wanted to increase the Lasix and add Potassium. - LPN also asked about prn Lasix but HWD explained the facility's unlicensed staff could not assess the residents. - The LPN first spoke with a medication aide who then asked the HWD to take the call. - The facility corporation prefers no verbal orders are taken even by licensed staff. - HWD requested the LPN fax written orders for the medications. - The written orders to increase Lasix and add Potassium were never received from the physician's office. - She called the LPN back but kept getting voice mail but she did not document these contacts. - She called the LPN's supervisor within a week to explain they did not receive the orders but she could not recall her name and she did not document the contact. - The supervisor was going to talk with the LPN but the HWD never heard back from the physician's office. - She did not try to contact the physician's office again after they received the Potassium on	D 358		

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D 358	Continued From page 38 07/19/15. - She was not sure how the Potassium got to the facility but she recalled a medication aide had asked her about it. - She did not call back to the physician's office or pharmacy after the Potassium was received on 07/19/15. - She did not contact them regarding the increase in Lasix because she thought since they only received the Potassium that was what the physician wanted. Interview with a medication aide (MA) on 08/21/15 at 11:10 a.m. revealed: - The Licensed Practical Nurse (LPN) from Resident #1's primary physician's office called about the resident's legs being swollen. - The LPN said they were going to increase the resident's Lasix and put her on Potassium. - The LPN asked the MA if she could give the resident a prn (as needed) dose of Lasix. - The MA asked the LPN how many days to give the prn Lasix and the LPN said until the swelling goes down. - The MA asked the LPN to give them a scheduled order for like 10 days. - She then asked the HWD to talk with the LPN. - Resident #1 had called the local independent pharmacy and ordered some denture cleaning supplies. - The pharmacy delivered the denture products on 07/19/15 to the resident's room and the Potassium was also in the bag. - The resident notified the MA and gave the bottle of Potassium to the MA. - The resident had not taken any of the Potassium. - The MA called the pharmacy and asked them to fax the order for the Potassium to the facility. - The pharmacy faxed the electronic prescription	D 358		

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BROOKDALE NEW BERN	1336 SOUTH GLENBURNIE ROAD NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 39 for Potassium to the facility on 07/19/15. - The order was then transcribed on the MAR and the resident received the first dose of Potassium on 07/20/15. - The independent pharmacy usually delivered to the medication room at the facility and it was unusual for them to deliver medications to the resident's room. - Resident #1 also used the primary pharmacy and the veteran's pharmacy but she did not fax the Potassium order to these pharmacies since it had already been dispensed. - She did not contact the pharmacy or physician regarding an increase in Lasix once the Potassium was received. - Lasix was never increased to her knowledge because they did not have a written order. Interview with the Health and Wellness Director / Registered Nurse (HWD) on 08/19/15 at 5:40 p.m. revealed: - Resident #1's left leg started weeping and swelling over the weekend. - The resident was sent to the emergency room and received no new orders. - She observed Resident #1's left leg weeping yesterday. - The residents' legs were chronically swollen. - She had not seen the resident's legs today and did not realize they were still weeping. Review of a physician's visit form dated 08/20/15 for Resident #1 revealed: - Resident was seen for follow-up for left leg redness/weeping. - Physician noted resident has chronic edema - no worse than usual; has ulcer upper anterior tibial area and lower anterior tibial area. - Physician wrote an order to try large band aids to upper and lower ulcers and change as needed.	D 358		

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D 358	Continued From page 40 - Physician wrote order to increase Lasix to 20mg daily and 40mg daily on Mondays, Wednesdays, and Fridays and follow-up in 2 weeks. Observation and interview of Resident #1 on 08/21/15 at 9:15 a.m. revealed: - The resident was wearing TED hose and both of her lower extremities were swollen. - There was an area of dark brown wet drainage stained on the TED hose on her left leg on the shin area. - The resident did not know if she received any medication for the swelling in her legs. - She did not know if she received Potassium. Interview with Resident #1 on 08/21/15 at 1:05 p.m. revealed: - She usually got her short-term medications from a local independent pharmacy. - Her long-term medications usually came from the veteran's mail order pharmacy. - She would sometimes call the local independent pharmacy to order supplies such as denture products and incontinence supplies. - The independent pharmacy would usually deliver the requested supplies to her room at the facility. - The independent pharmacy did not usually deliver any medications to her room. - She did not recall medication being delivered to her room but if they did, she would give it to the facility staff. B. Review of a Resident Log note dated 06/01/15 (11:30 a.m.) for Resident #1 revealed: - Resident was observed lying on floor in room. - Resident has medium size skin tear on left wrist and 2 small skin tears on left lower leg.	D 358		

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D 358	Continued From page 41 - All areas cleaned and dressed. - The physician was faxed. Review of a physician's order dated 06/03/15 for Resident #1 revealed an order to apply Nystatin or Neosporin to all of the resident's skin tears for the next 5 to 7 days or until healed. (Nystatin and Neosporin are topical medications used to treat skin infections.) Review of the June 2015, July 2015 and August 2015 medication administration records (MARs) revealed: - Order for Nystatin or Neosporin was not transcribed onto the June 2015 MAR. - No Nystatin or Neosporin was documented as administered in June 2015. - Computer-printed entry for Neosporin apply to skin tears as directed for 5 - 7 days or until healed on the July 2015 and August 2015 MARs. - There was no scheduled administration time noted on the MARs. - Neosporin was not documented as administered in July 2015 or August 2015. - Staff documented "healed" on the August 2015 MAR. Interview with a medication aide on 08/21/15 at 1:05 p.m. revealed: - She could not recall if Nystatin or Neosporin was put on Resident #1's leg for the skin tears after the fall on 06/01/15. - It should have been documented on the MAR if it was administered. Interview with a second medication aide on 08/20/15 at 10:35 a.m. revealed: - The resident had a wound on her leg that "got bad" a couple of months ago. - The medication aides were very concerned	D 358		

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D 358	Continued From page 42 about the resident's legs and it was brought to the HWD's attention more than once. - It got so bad the nurse finally looked at it. - The resident's leg had gotten better over the last couple of weeks. - She could not recall if Nystatin or Neosporin were administered. Review of Resident Log (RL) and Shift Report (SR) notes for Resident #1 revealed: - 06/07/15 (5:00 a.m.) (RL, SR): Dressing on skin tears got changed last night. Resident said her leg was hurting last night. - 06/14/15 (4:00 a.m.) (RL): Resident had some swelling and pain in her leg. Redressed her leg with looser dressing. - 06/17/15 (11:30 a.m.) (RL): Skin tear on left wrist looks good. Two skin tears on left leg area are red. Will continue to monitor. - 06/20/15 (7am - 7pm) (SR): Skin tears looks good on hand. Leg needs to be looked at. (SR was signed at bottom for review by ED and HWD). - 06/21/15 (7am - 7pm) (SR): Changed dressing on leg. Nurse need to look at leg. (SR was signed by ED and HWD). - 06/23/15 (9:15 a.m.) (RL): HWD documented left leg skin tear draining moderate amount of purulent / serosanguineous fluid periwound. Skin is red and edematous. Both lower extremities with 1+ pitting edema. Requested an order for wound clinic from primary physician's office. - 06/23/15 (3:20 p.m.) (RL): Received order for resident to be seen at urgent care to have leg evaluated. - 06/23/15 (4:00 p.m.) (RL): Received new order for Keflex 500mg every 8 hours until gone. (Keflex is an antibiotic for infection.) Review of a physician's visit form dated 06/23/15	D 358		

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D 358	Continued From page 43 revealed: - The resident presented with a wound to her left lower leg which occurred after a fall a few weeks ago. - She is having increased redness and pain around it. - There are 2 wounds over the distal anterolateral aspect. - The resident has chronic lower extremity edema and has 2 - 3+ pitting edema with a very slight erythematous hue to the skin from the mid tibial area to the ankle. - The resident was diagnosed with lower leg wound with cellulitis and the wounds were debrided. - The wound will be hard to heal with the edema and she may need to be sent to wound care clinic. - The resident received antibiotic via injection and order for antibiotic to take by mouth. Review of a physician's visit form dated 06/24/15: - The resident was given another antibiotic injection for lower leg wound with cellulitis. - Left leg has 2cm in diameter ulcerative lesion in left lower leg with at least a 5cm zone of surrounding erythema (redness). - Wound was caused by previous trauma to the left pretibial area with secondary infection. Review of a physician's visit form dated 06/25/15 revealed resident was seen for lower leg wound with cellulitis and daily wet to dry dressings were ordered. Review of a physician's visit form dated 06/30/15 revealed resident was seen for follow-up for lower leg wound with cellulitis and wound clinic consult was ordered.	D 358		

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D 358	Continued From page 44 Review of Resident #1's record revealed she was seen at the wound clinic on 07/09/15, 07/16/15, 07/23/15, 07/30/15, 08/06/15, and 08/13/15 (discharged due to wound healed). Review of medications on hand on 08/20/15 at 10:50 a.m. revealed there was no Neosporin or Nystatin on hand for Resident #1. Review of pharmacy dispensing records dated 02/22/15 - 08/20/15 from the primary pharmacy revealed no Nystatin or Neosporin had been dispensed by this pharmacy for Resident #1. Interview with a pharmacy technician at a local independent pharmacy on 08/20/15 at 9:28 a.m. revealed they had not dispensed any medications to Resident #1 since 2014 until they dispensed Potassium Chloride tablets on 07/09/15. Interviews with Resident #1 on 08/21/15 at 9:15 a.m. and 1:05 p.m. revealed: - She usually got her short-term medications from a local independent pharmacy. - Her long-term medications usually came from the veteran's mail order pharmacy. - The resident did not know if she received any topical medication for the skin tears after her fall in June 2015. - She recalled going to the wound clinic for cellulitis but she did not go to the clinic anymore. Interview with the Health and Wellness Director / Registered Nurse (HWD) on 08/21/15 at 11:00 a.m. revealed: The Nystatin and Neosporin order should have been transcribed on the MAR. - The facility has individual packets of Neosporin in the first aid kits but they do not keep house stock. - She did not know if the Nystatin or Neosporin	D 358		

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D 358	Continued From page 45 was administered. - Resident #1 had recently been discharged from the wound clinic because her leg wound had healed. Interview with the Resident Care Coordinator (RCC) on 08/20/15 at 4:30 p.m. revealed: - She usually checked the new MARs each month for accuracy. - The HWD usually checked the new order tracking. - She did not know if Nystatin or Neosporin were administered to Resident #1. Telephone interview with the nurse from the wound clinic on 08/20/15 at 3:10 p.m. revealed: - Resident #1 was referred to the wound clinic on 06/30/15 and her initial visit was on 07/09/15. - When the resident was first seen at the wound clinic, she had weeping blisters on her left leg. 3. Review of Resident #5's FL2 dated 4/24/15 revealed the diagnosis included Ambulatory Dysfunction, Hypertension, Dementia and Prostatin. Review of hospital discharge instructions and electronic written prescription for Resident #5's revealed: -Physician orders on 5/6/15 for Ultram 50mg by mouth every 12 hours as needed for pain for 3 days (Ultram is used to treat pain). Review of Resident #5's May 2015 medication administration record (MARs) revealed: - Order for Ultram 50mg PO q12 hrs. PRN Pain x 3 days was transcribed on the MAR on 5/6/15 with days blocked off for administration on 5/7/15 - 5/9/15. - One dose of Ultram 50mg had been given on	D 358		

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D 358	Continued From page 46 5/9/15 (no time documented.) "Done 5/9/15" was written on the MAR. - The transcribed order by the Med Aide was cosigned by the Health and Wellness Director (HWD) and Resident Care Coordinator (RCC). Review of Resident #5's June 2015 MARs revealed the resident had received Ultram 50mg on June 5, 2015. Review of Resident #5's Control Substance Receipt/Count Sheet revealed: - The facility received six tablets of Ultram (no documation of date received) from the order dated 5/6/15. - On 5/9/15 at 9:00am 1 tablet of Ultram 50mg was administered. - On 5/10/15 at 8:00am 1 tablet of Ultram 50mg was administered. - On 5/11/15 at 8:00am 1 tablet of Ultram 50mg was administered. - On 6/5/15 at 8:00pm 1 tablet of Ultram 50mg was administered. Interview with HWD on 8/19/15 at 5:35 pm revealed: - All orders transcribed to the MAR by Med Aide are supposed to be cosigned by HWD or RCC on next business day to assure the orders were transcribed as ordered. Interview with a Medication Aide on 8/20/15 at 9:20 am revealed: - The medication aide transcribed the order to the May 2015 MAR on 5/6/15. - The Medication ordered was faxed to the pharmacy (date unknown). - The medication was received by the facility (date unknown). - There was no further orders obtained from	D 358		

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D 358	Continued From page 47 the physician for Ultram to be administered after 5/9/15. - The resident had not complained of pain until the 3rd day after receiving the order on 5/6/15. - The medication had been administered to the resident because he complained of pain on 5/10/15. - The resident should not have received the medication because the order was for 3 days. - The medication aides are supposed to obtain new order from the physician when orders are discontinued. Staff should have faxed a request stating it was needed. Interview with HWC on 8/20/15 at 10:15am revealed: - Medication Ultram 50mg was administered outside of physician order on 5/10/15, 5/11/15 and 6/5/15. - Medications that are discontinued should had been removed from medication cart and returned to pharmacy. Interview with Executive Director (ED) on 8/20/15 at 4:30 pm revealed: - Orders received from the physician are supposed to be transcribed to the MAR by the Med Aide and faxed to pharmacy. - The Med Aides are supposed to sign, date and time what was written on the MAR. - Orders are checked on next business day and signed off by RCC or HWD for accuracy of transcription and completion. --- Review of the facility's plan of protection dated 08/21/15 revealed: - Medication errors identified during the survey will be reported as required by the Health & Wellness Director (HWD), Resident Care	D 358		

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D 358	Continued From page 48 Coordinator (RCC), and/or designee. - Voltaren gel will be clarified, dosing appliance has been requested, and instruction for Voltaren gel will be completed on each shift. - HWD, RCC, and/or designee will immediately begin a complete medication administration record (MAR), chart, and cart audit to assure compliance. - Clarifications will be done as needed and documented in the Resident Log. - A complete MAR audit will be done by the RCC and HWD, including clarification by 08/31/15. - All new medication orders will be reviewed by the HWD, RCC, Executive Director (ED), and/or designee prior to the administration of the medication. - RCC, HWD, and/or designee will conduct random medication pass observations 3 times per week and as needed for the next 2 months, then weekly for 2 months, then as needed audits will be ongoing. - RCC, HWD, and/or designee will conduct random MAR and cart audits 3 times per week and as needed for the next 2 months, then weekly for 2 months, then as needed audits will be ongoing. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 5, 2015.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 49 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care and medication administration. The findings are: 1. Based on observation, record review, and interview, the facility failed to notify the physician of increased leg swelling and redness around a leg wound until at least 8 days after swelling and pain were documented; failed to schedule a follow-up appointment related to an emergency room visit for leg swelling, redness, and weeping; and failed to make a dermatology appointment for excessive dry skin/flaking and warts on left arm and hand for 1 of 5 residents (#1) sampled for health care. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).] 2. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 2 of 14 residents (#1, #6) observed during the medication passes, including errors with an antibiotic for a dental procedure, an antibiotic eye ointment, and topical gel for pain and inflammation and 2 of 5 residents (#1, #5) sampled for review related to errors with pain medication, a diuretic for swelling, a potassium supplement, and topical antibiotic ointments. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	D912		