

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL063024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE PINEHURST		STREET ADDRESS, CITY, STATE, ZIP CODE 17 REGIONAL DRIVE PINEHURST, NC 28374			
(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 11/24/15 and 11/25/15.	D 000			
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 6 staff (Staff D) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G. S. 131E-256. The findings are: Review of Staff D's personnel records revealed: -A hire date of 07/13/15. -Documentation of a Health Care Personnel Registry check on 11/25/15 with no substantiated findings. Review of September, October and November 2015 Medication Administration Records (MARs) revealed: -Staff D worked at the facility as a Medication Aide (MA) 9 days in September. -Staff D worked at the facility as a Medication Aide (MA) 8 days in October. -Staff D worked at the facility as a Medication Aide (MA) 8 days in November.	D 137			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE
Executive Director

DATE
12/24/15

STATE FORM

5509

FMT611

If continuation sheet 1 of 25

Reviewed & Accepted
[Signature]
12/28/15

The following is a summary of the Plan of Correction for Brookdale Pinehurst. This Plan of Correction is in regards to the Statement of Deficiencies dated 12/10/15. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

Plan of Protection for rule Violation 10A NCAC 13F .1004 (a).

Medications will be administered as ordered by physician starting immediately.

Begin Audit immediately of all resident records to ensure orders on MAR match Physician orders.

Immediate audit of Medication cart medications to ensure medications on hand are as ordered by Physician.

Any discrepancies noted during above audits will be clarified immediately.

Medication techs to be in-serviced prior to next scheduled shift.

Pharmacy to re-in-service Medication Techs on Diabetic training and MAR documentation to ensure 100% completion by 1/11/16.

All Medication Techs re-in-service on Resident #1's Insulin orders to ensure understanding prior to next scheduled shift. 100% completion on 11/30/15.

Resident #7 Seroquel order was corrected on 11/26/15.

Above Plan of Protection was completed on 11/30/15.

1. 10A NCAC 13F .0407 Other staff qualifications

(a) Each staff person at an adult care home shall:

(5) Have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256

- An audit will be completed on associate files by Business Office Coordinator.
- The identified employees missing documentation was checked in the Health Care Registry with documentation placed in their file.
- A tracking system will be developed for tracking compliance by the business office coordinator/Executive Director/Designee.

- Thereafter the tracking system will be checked at least monthly by the Business Office Coordinator and Quarterly by the Executive Director/Designee for compliance.
- The Date of Correction will not exceed January 21, 2016.

2. G.S. 131D-21 Declaration of Residents' Rights.

G.S. 131D-21 Declaration of Resident' 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.

- Appropriate associates will be retrained on the community's policy regarding Resident Rights in regards to receiving medications as ordered.
- Business Office Coordinator/Executive Director/Designee will track for compliance.
- Thereafter the tracking system will be reviewed monthly by the Business Office Coordinator and Quarterly by the Executive Director/Designee for compliance.
- The Date of Correction will not exceed January 21, 2016.

3. 10A NCAC 13F .1009 (a)(1)Pharmaceutical Care

10A NCAC 13F .1009 Pharmaceutical Care

- (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk.

Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following:

- (A) The review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication errors are identified and reported to the appropriate prescribing practitioner; and
- (B) Making recommendations or change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and
- (C) Documenting the results of the medication review in the resident's record.

- Regional Clinical Manager in-serviced consultant pharmacist on 12/18/15 regarding importance of careful review of MAR and notification to facility of potential medication irregularities.
- On 11/29/15 Neil Medical Group Regional Clinical Manager (registered pharmacist) from provider pharmacy and Resident Care Coordinator audited all December MARs to ensure accuracy of orders.
- Consultant pharmacist will continue to conduct a Medication Regimen Review quarterly for all residents.
- Following the next scheduled Medication Regimen Review, Regional Clinical Manager from contracted pharmacy will also conduct 100% review of all resident's records to assess compliance.
- QA technician from provider pharmacy will conduct a MAR to cart audit monthly for three months to ensure medication/ label on cart matches that on MAR.
- The provider pharmacy Regional Clinical Manager will conduct an onsite 100% audit of medication regimen documentation for residents receiving insulins monthly for three months.
- Seroquel issue: indicate that facility and pharmacy staff completed 100% audit on 11/25 and 11/26 to confirm that medications and inventory matched current orders for each resident.
- On 11/29/15 Neil Medical Group Regional Clinical Manager (registered pharmacist) from provider pharmacy and Resident Care Coordinator audited all December MARs to ensure accuracy of orders.
- Health and Wellness Director/Resident Care Coordinator/Designee will monitor monthly for three months then quarterly thereafter for compliance.
- The date of correction will not exceed January 21, 2016.

4. 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 facility's policies and procedures.
- Staff has been re-trained that they are required to seek clarification for any orders that are incomplete or unclear.
 - Medication Techs had State approved Diabetic Training with 100% attendance completed on 11/18/15.

- Health and Wellness Director/Resident Care Coordinator/Designee completed a retraining/review of New Order Tracking form to assure that any orders that are received will be transcribed, clarified if needed, and followed as indicated.
- MARS are being and will continue to be reviewed no less than weekly by the Health and Wellness Director/Resident Care Coordinator/Designee assuring that administration has been appropriately documented for the next two months. Thereafter, such reviews will be conducted at least once per week. Compliance findings will be reported to the Executive Director or Designee for review.
- MAR to chart audit will be completed monthly by the Resident Care Coordinator.
- The Date of Correction for this Type A2 Violation is December 25, 2015.

5. G.S. 131D-4.5B. (a)ACH Infection Prevention Requirements

G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements

(a.) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5

- Annual Medication Aide state approved infection control training to be completed by 12/31/15. Training provided by Health and Wellness Director.
- Certificates provided and to be placed in associates' permanent record.
- A tracking system will be developed for tracking compliance by the business office coordinator/Executive Director/Designee no later than 12/31/15.
- Thereafter the tracking system will be checked at least monthly by the Business Office Coordinator and Quarterly by the Executive Director/Designee for compliance.
- The Date of Correction will not exceed January 21, 2016.

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D 137	Continued From page 1 Interview with Staff D on 11/25/15 at 5:10 pm revealed: -She worked as a Medication Aide. -Her job duties included giving medications and providing personal care to residents. -She did not know if a HCPR check had been completed by the facility prior to hire. Interview with the Business Office Manager on 11/25/15 at 3:45 pm revealed: -She did not know if a HCPR check had been completed prior to 11/25/15 on Staff D. -She was unable to locate a HCPR check for Staff D prior to 11/25/15.	D 137		
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 A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications (Lantus and Humalog insulin, Seroquel) were administered as ordered by a licensed prescribing practitioner for 2 of 6 sampled residents (Residents #1 and #7).	D 358		

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D 358	Continued From page 2 The findings are: A. Review of Resident #1's current FL-2 dated 08/24/15 revealed: -Diagnoses included Type I diabetes mellitus, dementia, and renal insufficiency. -An order for fingerstick blood sugars (FSBSs) four times daily at breakfast, lunch, supper, and bed time. 1. Further review of the 08/24/15 FL-2 for Resident #1 revealed: -An order for Novolog insulin 1 unit with each meal three times daily. (Novolog is a rapid-acting insulin used to lower blood sugar levels.) -If FSBS less than 85, give 12 ounces orange juice and repeat FSBS in one hour. Repeat orange juice if still less than 85 and call the doctor. -The FL-2 did not include orders for holding insulin. Review of Resident #1's record revealed: -A physician's order dated 08/28/15 for Novolog 1 unit at breakfast and 3 units with lunch and supper. -No additional orders regarding FSBS results or for holding insulin. Review of the October 2015 Medication Administration Record (MAR) and FSBS log revealed: -The FSBSs ranged from 43 to 443. -Novolog insulin was circled as withheld or not documented as administered on 21 occasions without a physician's order for FSBSs ranging from 45 to 308. Examples of Novolog insulin withheld or not documented as administered without a	D 358		

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D 358	Continued From page 3 physician's order included: -On 10/09/15 at 5:00 pm, insulin was circled as withheld due to "blood sugar 149". -On 10/18/15 at 8:00 am, insulin was not documented as administered. FSBS was 217. -On 10/15/15 at 12:00 pm, insulin was circled as withheld with no documentation of the reason for withholding. FSBS was 268. -On 10/23/15 at 5:00 pm, insulin was circled as withheld with no documentation of the reason for withholding. FSBS was 295. -On 10/26/15 at 5:00 pm, insulin was circled as withheld due to "blood sugar 105". -On 10/27/15 at 12:00 pm, insulin was circled as withheld with no documentation of the reason for withholding. FSBS was 107. Review of the November 2015 MAR and FSBS log revealed: -The FSBS ranged from 43 to 547. -Novolog insulin was withheld or not documented as administered on 15 occasions without a physician's order for FSBSs ranging from 41 to 332. Examples of Novolog insulin withheld or not documented as administered without a physician's order included: -On 11/06/15 at 5:00 pm, insulin was not documented as administered. FSBS was 209. -On 11/14/15 at 5:00 pm, insulin was circled as withheld due to "blood sugar 67". -On 11/16/15 at 5:00 pm, insulin was not documented as administered. FSBS was 103. -On 11/17/15 at 5:00 pm, insulin was not documented as administered. FSBS was 128. -On 11/20/15 at 8:00 am, insulin was circled as withheld with no documentation of the reason for withholding. FSBS was 94.	D 358		

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D 358	Continued From page 4 Interview on 11/24/15 at 12:58 pm with a Medication Aide (MA) revealed: -She routinely held insulin whenever the FSBS was low, at 85 or below. -She considered a FSBS of 85 to be low because that was what the physician considered to be low. She knew this because he ordered orange juice for FSBSs below 85. -The resident's blood sugars "bottomed out" very easily. -She did not call the physician to obtain an order to hold the insulin, but just "automatically" held it if the FSBS was below 85. -She did not know why insulin was not given on occasions when the FSBS was above 85. Interview on 11/25/15 at 6:55 am with a second MA revealed: -She routinely held insulin if a FSBS was low, and did not call the physician for an order. -She mistakenly documented administering the Novolog at 8:00 am on 11/22/15 when the FSBS was 547. -She did not administer the Novolog on 11/22/15 because the FSBS was "too high". -The FSBS "was really 596 the first time, then 547" on a recheck. -The FSBS was 535 at lunch, so she resumed the insulin at lunch. -She gave the 12:00 pm dose of insulin because it (the FSBS) was coming down, so she "figured" if she gave the insulin to the resident, it would come down even more. Interview on 11/25/15 at 7:07 am with a third MA revealed: -She routinely held the resident's insulin if the FSBS was less than 85, but she did not call the physician for an order to hold the insulin. -She was the MA on duty on 10/18/15 at 8:00	D 358		

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D 358	Continued From page 5 when the FSBS was 217 and there was no documentation of insulin administration. -She was sure she administered the insulin and just forgot to document it. Interview on 11/25/15 at 11:12 pm with a fourth MA revealed: -She routinely held the resident's insulin if the FSBS was less than 85, but did not call the physician for an order to hold the insulin. -She was the MA on duty on 11/20/15 at 8:00 am when the FSBS was 94 and the insulin was withheld. -She did not give the morning insulin because the resident did not get out of bed right away. -She gave the morning insulin later but must have forgotten to document it. Interview on 11/25/15 at 9:52 am with Resident #1's physician revealed: -He had not provided parameters for holding insulin. -It was okay for staff to hold the resident's Novolog insulin if his FSBS was below 85. -The insulin should not be held when the FSBS is above 85. Interview on 11/24/15 at 3:48 pm with the interim Health and Wellness Director (HWD) revealed: -She had been working in the facility full time for the past 60 days. -She was filling in as HWD until the facility could hire a replacement. -She held diabetic training on 11/18/15 because she had noticed "issues" when she audited resident records, MARs, and pharmacy reviews. -Insulin should never be held without a physician's order. -During the diabetic training, the MAs were instructed to hold insulin for low FSBSs, but that	D 358		

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D 358	Continued From page 6 was supposed to be only while they called the doctor for an order. -FSBSs considered "low" would be different for individual residents; however, Resident #1's FSBS was considered low if it was below 85. -She routinely checked the MARs at the end of every month, but usually looked mainly to see if the new MAR matched the previous month. -She did not specifically monitor whether or not staff was getting physician orders prior to withholding insulin or if the insulin was being withheld appropriately. Interview on 11/25/15 at 4:14 pm with Resident #1's Power of Attorney (POA) revealed: -The resident was a "brittle diabetic". -It was not uncommon for the resident's FSBSs to range from 40 to 400. -The resident had been on a sliding scale insulin regimen at home, but the facility did not accept sliding scale insulin, so it was discontinued when he was admitted to the facility in August and new insulin orders written. -She felt the facility had "been doing fairly well" with managing the resident's FSBSs. Based on observations, interviews with staff, and record review, it was determined Resident #1 was not interviewable. 2. Review of the 08/24/15 FL-2 for Resident #1 revealed: -A physician's order for Lantus 10 units daily at breakfast. -No orders for holding Lantus insulin. Review of the September 2015 Medication Administration Record (MAR) revealed there were two occasions when the Lantus insulin was circled as not administered.	D 358		

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D 358	Continued From page 7 -On 09/18/15 at 8:00 am, Lantus was circled as not administered due to "low blood sugar reading all night. FSBS was 109. Subsequent FSBSs were 299 at 12:00 pm, 118 at 5:00 pm, blank at 8:00 pm, and 261 at 8:00 am on 09/19/15. -On 09/25/15 at 8:00 am, Lantus insulin was circled as not administered due to "low blood sugar-51". Subsequent FSBSs were 185 at 12:00 pm, 138 at 5:00 pm, 190 at 8:00 pm, and 567 at 8:00 am on 09/26/15. Review of the October 2015 MAR revealed there were three occasions when the Lantus was withheld or not documented as administered. -On 10/18/15 at 8:00 am, Lantus was not documented as administered. FSBS was 217. Subsequent FSBSs were 121 at 12:00 pm, 71 at 5:00 pm, 193 at 8:00 pm, and 66 at 8:00 am on 10/19/15. -On 10/19/15 at 8:00 am, Lantus was not documented as administered. FSBS was 66. Subsequent FSBSs were 109 at 12:00 pm, 77 at 5:00 pm, 279 at 8:00 pm, and 214 at 8:00 am on 10/20/15. -On 10/27/15 at 8:00 am, Lantus was withheld. FSBS was 59. Subsequent FSBSs were 107 at 12:00 pm, 344 at 5:00 pm, 300 at 8:00 pm, and 258 at 8:00 am on 11/28/15. Review of the November 2015 MAR revealed there were four occasions when the Lantus was circled as withheld. Examples included: -On 11/20/15 at 8:00 am, Lantus was withheld with no reason documented. FSBS was 94. Subsequent FSBSs were 223 at 12:00 pm, 299 at 5:00 pm, 314 at 8:00 pm, and 404 at 8:00 am on 11/21/15. -On 11/21/15 at 8:00 am, Lantus was withheld with reason documented. FSBS was 404. Subsequent FSBSs were 398 at 12:00 pm, 404 at	D 358		

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D 358	Continued From page 8 5:00 pm, 496 at 8:00 pm, and 547 at 8:00 am on 11/22/15. Interview on 11/25/15 at 6:55 am with a Medication Aide (MA) revealed: -She routinely held all insulin, including Lantus, if a FSBS was low, and did not call the physician for an order. -She mistakenly circled the Lantus as withheld on 11/21/15 when the FSBS was 404. -She meant to circle the Lantus documented as administered on 11/22/15 when the 8:00 am FSBS was 547. -She did not administer the Lantus on 11/22/15 because the FSBS was "too high". -The FSBS "was really 596 the first time, then 547" on a recheck. Interview on 11/25/15 at 7:07 am with a second MA revealed: -She routinely held the resident's insulin, including Lantus, if the FSBS was less than 85, but she did not call the physician for an order to hold the insulin. -She was the MA on duty on 10/18/15 at 8:00 when the FSBS was 217 and there was no documentation of Lantus administration. -She was sure she administered the insulin and just forgot to document it. Interview on 11/25/15 at 11:12 pm with a third MA revealed: -She routinely held the resident's insulin, including Lantus, if the FSBS was less than 85, but did not call the physician for an order to hold the insulin. -She was the MA on duty on 11/20/15 at 8:00 am when the FSBS was 94 and the insulin was withheld. -She did not give the Lantus insulin because the resident did not get out of bed right away.	D 358		

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D 358	Continued From page 9 -She gave the insulin later but must have forgotten to document it. Interview on 11/25/15 at 9:52 am with Resident #1's physician revealed: -He had not provided parameters for holding insulin. -The Lantus insulin should not be held, even when the morning FSBS is low, because it causes subsequent FSBSs to be elevated. -He was not aware staff were withholding the Lantus insulin. Interview on 11/24/15 at 3:48 pm with the interim Health and Wellness Director (HWD) revealed: -She had been working in the facility full time for the past 60 days. -She was filling in as HWD until they facility could hire a replacement. -She held diabetic training on 11/18/15 because she had noticed "issues" when she audited resident records, MARs, and pharmacy reviews. -Insulin should never be held without a physician's order. -During the diabetic training, the MAs were instructed to hold insulin for low FSBSs, but that was supposed to be only while they called the doctor for an order. -She routinely checked the MARs at the end of every month, but usually looked mainly to see if the new MAR matched the previous month. -She did not specifically monitor whether or not staff was getting physician orders prior to withholding insulin or if the insulin was being withheld appropriately. Interview on 11/25/15 at 4:14 pm with Resident #1's Power of Attorney (POA) revealed: -The resident was a "brittle diabetic". -It was not uncommon for his FSBSs to range	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL063024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE PINEHURST		STREET ADDRESS, CITY, STATE, ZIP CODE 17 REGIONAL DRIVE PINEHURST, NC 28374		
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D 358	Continued From page 10 from 40 to 400. -He had been on a sliding scale insulin regimen at home, but the facility did not accept sliding scale insulin, so it was discontinued when he was admitted to the facility in August and new insulin orders written. -She felt the facility had "been doing fairly well" with managing the resident's FSBSs. Based on observations, interviews with staff, and record review, it was determined Resident #1 was not interviewable. 3. Review of the 08/24/15 FL-2 for Resident #1 revealed an order to administer Novolog 1 unit with each meal three times daily. Review of Resident #1's physician orders revealed: -A physician's order dated 08/28/15 to administer Novolog 1 unit at breakfast and 3 units at lunch and dinner. If the FSBS is greater than 500, give 3 units, repeat FSBS in 2 hours and call the physician if still greater than 500. Review of the September 2015 Medication Administration Record (MAR) revealed: -The order to administer Novolog 3 units for FSBS greater than 500 was transcribed to the MAR. -There were four occasions when the FSBS was greater than 500 and the Novolog 3 units was not documented as administered. -On 09/01/15 at 5:00 pm, FSBS was 550 with no documentation of additional Novolog administered. -On 09/01/15 at 8:00 pm, FSBS was 515 with no documentation of Novolog administered. -On 09/26/15 at 8:00 am, FSBS was 567 with no documentation of additional Novolog administered.	D 358		

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D 358	Continued From page 11 -On 09/26/15 at 12:00 pm, FSBS was 556 with no documentation of additional Novolog administered. Review of the October 2015 MAR revealed: -The order to administer Novolog 3 units for FSBS greater than 500 was electronically printed on the MAR, but was not separated from the standing insulin order of Novolog 3 units with lunch and dinner. -There were no documented FSBSs greater than 500. Review of the November 2015 MAR revealed: -The order to administer Novolog 3 units for FSBS greater than 500 was electronically printed on the MAR, but was not separated from the standing insulin order of Novolog 3 units with lunch and dinner. -There were two occasions when the FSBS was greater than 500 with no documentation of additional Novolog administered. -On 11/22/15 at 8:00 am, FSBS was 547 with no documentation Novolog 3 units was administered. -On 11/22/15 at 12:00 pm, FSBS was 535 with no documentation Novolog 4 units was administered. Interviews on 11/24/15 and 11/25/15 at various times with five MAs revealed they did not realize the Novolog 3 units was to be administered for FSBSs greater than 500 in addition to standing insulin orders. Interview on 11/25/15 at 9:52 am with Resident #1's physician revealed: -He intended for staff to administer 3 units of Novolog for FSBSs greater than 500, in addition to standing insulin orders. -He was not aware staff were not administering the additional insulin.	D 358		

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D 358	Continued From page 12 Interview on 11/24/15 at 3:48 pm with the interim Health and Wellness Director (HWD) revealed: -She had been working in the facility full time for the past 60 days. -She was filling in as HWD until the facility could hire a replacement. -She held diabetic training on 11/18/15 because she had noticed "issues" when she audited resident records, MARs, and pharmacy reviews. -She routinely checked the MARs at the end of every month, but usually looked mainly to see if the new MAR matched the previous month. -She did not specifically check to see if the additional Novolog was administered for FSBSs over 500 as ordered by the physician. Interview on 11/25/15 at 4:14 pm with Resident #1's Power of Attorney (POA) revealed: -The resident was a "brittle diabetic". -It was not uncommon for his FSBSs to range from 40 to 400. -He had been on a sliding scale insulin regimen at home, but the facility did not accept sliding scale insulin, so it was discontinued when he was admitted to the facility in August and new insulin orders written. -She felt the facility had "been doing fairly well" with managing the resident's FSBSs. Based on observations, interviews with staff, and record review, it was determined Resident #1 was not interviewable. B. Review of Resident #7's current FL-2 dated 04/08/15 revealed diagnoses included Alzheimer's dementia, hypertension, and hyperlipidemia. Review of Resident #7's record revealed:	D 358		

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D 358	Continued From page 13 -A physician's order dated 08/25/15 for quetiapine fumarate (generic for Seroquel) 100 mg twice daily as needed. (Seroquel is an antipsychotic medication.) -A physician's order dated 08/28/15 for quetiapine fumarate 50 mg twice daily. Observation of the morning medication pass on 11/25/15 at 7:37 am revealed: -The Medication Aide (MA) prepared Resident #7's morning medications for administration. -After reviewing the pharmacy label on the bubble pack of Seroquel, the MA replaced the Seroquel and did not administer it with the other morning medications. Interview on 11/25/15 at 7:38 am with the MA revealed she did not have Seroquel 50 mg on hand to administer to the resident and would have to order the Seroquel from the pharmacy. Observation on 11/25/15 at 7:40 am of Resident #7's medications on hand revealed: -There were no Seroquel 50 mg tablets available for administration to Resident #7. -There was a bubble pack of Seroquel 100 mg tablets. Review on 11/25/15 at 7:40 am of the pharmacy label for the Seroquel 100 mg tablets revealed: -Sixty tablets of Seroquel 100 mg were dispensed from the pharmacy on 10/26/15 with instructions to administer one tablet twice daily as needed. -There were two tablets remaining in the bubble pack. Review of the August 2015 Medication Administration Record (MAR) revealed: -An entry for quetiapine fumarate 100 mg twice daily prn (as needed).	D 358		

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D 358	Continued From page 14 -Quetiapine fumarate 100 mg was documented as administered twice on 08/27/15. -An entry for quetiapine fumarate 50 mg twice daily at 8:00 am and 8:00 pm. -Quetiapine fumarate 50 mg was documented as administered twice daily from 08/28/15 at 8:00 pm through 08/31/15 at 8:00 pm. Review of the September 2015 MAR revealed: -A handwritten entry for Seroquel 100 mg twice daily as needed with no documentation of administration. -A handwritten entry for Seroquel 50 mg twice daily at 8:00 am and 8:00 pm. -Seroquel 50 mg was documented as administered twice daily from 09/01/15 through 09/30/15. Review of the October 2015 MAR revealed: -A computer-generated entry for Seroquel 50 mg twice daily at 8:00 am and 8:00 pm. -Seroquel 50 mg was documented as administered twice daily from 10/01/15 through 10/31/15. Review of the November 2015 MAR revealed: -A computer-generated entry for Seroquel 50 mg twice daily at 8:00 am and 8:00 pm. -Seroquel 50 mg was documented as administered twice daily from 11/01/15 through 11/24/15. Review of a staff note dated 11/11/15 at 11:55 am from the interim Health and Wellness Director (HWD) revealed: -Resident #7's Responsible Party (RP) reported that the resident "could not lift his head" on 11/07/15, 11/08/15, and 11/10/15. -The RP reported she had tried to lift the resident's head with no success.	D 358		

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D 358	Continued From page 15 -The HWD assessed Resident #7 and observed him sitting at the dining room table holding his head up without difficulty. -The HWD spoke with staff, who denied "issues", but reported the resident had not been sleeping well and when that happened, he slept in a chair with his head down. -The HWD did not observe the resident to have any neck weakness or difficulty holding his head up during her assessment. -The RP was taking the resident to the neurologist later on 11/11/15. Interview on 11/25/15 at 7:41 am with the MA revealed: -She did not realize until the 11/25/15 morning medication pass the Seroquel tablets were 100 mg instead of 50 mg. -Staff had been administering 100 mg twice daily instead of 50 mg. Telephone interview on 11/25/15 at 8:37 am with a representative from the facility's contracted pharmacy revealed: -The pharmacy did not routinely provide the medications for Resident #7, but tracked his medication orders and generated the monthly MAR. -The facility did not provide them with the 08/25/15 order for Seroquel 100 mg and they were unaware of it. -On 08/29/15, the facility faxed an order for Seroquel 50 mg twice daily. -On 08/29/15, the pharmacy dispensed 30 tablets of Seroquel 50 mg tablets, but the 30 tablets were sent back to the pharmacy. Telephone interview on 11/25/15 at 9:05 am with a representative from a local pharmacy revealed: -The pharmacy routinely dispensed medications	D 358		

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D 358	Continued From page 16 for Resident #7. -Sixty tablets of Seroquel 100 mg were dispensed on 08/25/15, 09/26/15, and 10/26/15. -They were not aware the physician changed the Seroquel dosage on 08/28/15 to 50 mg twice daily. -The facility did not fax the 08/28/15 order to this pharmacy. Interviews on 11/25/15 at various times with three additional MAs revealed: -They did not realize they had been administering the incorrect dosage of Seroquel. -They did not carefully compare the medication label with the instructions on the MAR. -They had not noticed Resident #7 to appear lethargic or oversedated. -MAs were not responsible for conducting medication cart audits; the nurse was "usually responsible" for conducting the audits, but they "haven't had one (a nurse)". Interview on 11/25/15 at 11:45 am with the nurse from Resident #7's neurologist's office revealed: -The Seroquel was decreased from 100 mg tablets to 50 mg because (named facility staff) the facility's HWD contacted the physician's office on 08/27/15 and requested the dosage be changed because the resident became too sedated when administered the 100 mg tablets. -The resident was last seen in the office on 11/11/15. -The resident was accompanied by a family member who reported the resident was having trouble holding his head up. -The physician's note for the 11/11/15 visit documented the resident's current dose of Seroquel at 50 mg twice daily and the physician's order was to continue the Seroquel at the current dose.	D 358		

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D 358	Continued From page 17 -The physician was unaware the resident had been receiving 100 mg of Seroquel twice daily instead of the ordered 50 mg. Interview on 11/25/15 at 12:11 am with Resident #7's family member revealed: -Sometimes the resident had trouble holding his head up, but at other times he did not have any trouble. -She first noticed the resident having this trouble around 11/07/15. -She scheduled an appointment with the resident's neurologist for 11/11/15, but by the time the resident went for the appointment, he "was better". -She was not aware of the resident's current medication dosages. Interview on 11/24/15 at 3:48 pm with the interim Health and Wellness Director (HWD) revealed: -She had been working in the facility full time for the past 60 days. -She was filling in as HWD until they facility could hire a replacement. -She routinely checked the MARs at the end of every month, but usually looked mainly to see if the new MAR matched the previous month. -She did not monitor to ensure orders on the MAR matched current physician orders or that ordered medications were on hand and available for administration. Observations of Resident #1 on 11/24/15 and 11/25/15 at various times revealed the resident was awake and alert without obvious evidence of oversedation. Based on observations, interviews with staff, and record review, it was determined Resident #7 was not interviewable.	D 358		

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D 358	Continued From page 18 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 25, 2015.	D 358			
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record.	D 400			

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D 400	Continued From page 19 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the on-site medication review included the review of medication administration records to determine that medications were administered as prescribed to 2 of 6 sampled residents (Residents #1 and #7). The findings are: Review of the Medication Regimen Review dated 11/03/15 revealed: -The medication review was completed for 53 residents, including Residents #1 and #7. -There were no medication administration discrepancies identified in the review for either resident. Review of resident records revealed medication administration discrepancies for Residents #1 and #7. Interview on 11/25/15 at 12:21 pm with the Pharmacist revealed: -He completed the Medication Regimen Review on 11/03/15. -During his review, he "generally" looked at the current Medication Administration Records to ensure accurate administration of medications. -He did not recall seeing any issues for Residents #1 or #7. -If medication administration issues had been identified during the review, they would have been included in the recommendations.	D 400		

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D 400	Continued From page 20 Interview on 11/25/15 at 9:50 am with the Executive Director revealed: -The pharmacy reviews were completed quarterly and recommendations followed up by the Health and Wellness Director (HWD). -She assumed the consulting pharmacist performed a complete review quarterly. -She was not aware of the medication administration discrepancies or that the discrepancies were not identified by the consulting pharmacist during his last review. Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).	D 400		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure medications (Lantus and Humalog insulin, Seroquel) were	D912		

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D912	Continued From page 21 administered as ordered by a licensed prescribing practitioner for 2 of 6 sampled residents (Residents #1 and #7). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	D912		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure all medication aides received annual in-service training for infection control for 2 of 2 sampled Staff (Staff C and E). The findings are: A. Review of Staff C's personnel record revealed: -A hire date of 7/15/08 and employed as a Medication Aide (MA). -A Medication Clinical Skills checklist completed	D934		

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D934	Continued From page 22 on 2/02/09. -Documentation of Infection Control training 12/31/12. -There was no signed certificate of annual infection control training. Staff C was unavailable for interview. Interview on 11/25/15 at 3:40 pm with the Business Office Manager revealed: -She did not know if Staff C had completed the annual infection control training. -She was unable to locate a signed certificate of completion of the training for Staff C. -She was unaware that all MAs and supervisors were required to take annual infection control training. -She was new to this position and learning all the staffing requirements. Refer to interview on 11/25/15 at 4:21 pm with the Pro time Nurse. Refer to interview on 11/25/15 at 4:28 pm with the Administrator. B. Review of Staff E's personnel record revealed: -A hire date of 01/13/09 as a Resident Assistant. -Staff E became a MA at the facility on 09/26/12. -A Medication Clinical Skills checklist completed on 04/19/12. -Staff E passed the MA test on 09/24/12. -Documentation of Infection Control training on Exposure Control on 10/22/14. -There was no signed certificate of the annual infection control training. Staff E was unavailable for interview.	D934		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL063024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE PINEHURST		STREET ADDRESS, CITY, STATE, ZIP CODE 17 REGIONAL DRIVE PINEHURST, NC 28374		
(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
D934	Continued From page 23 Interview on 11/25/15 at 3:40 pm with the Business Office Manager revealed: -She did not know if Staff E had completed the annual infection control training. -She was unable to locate a signed certificate of completion for the annual infection control training for Staff C. Refer to interview on 11/25/15 at 4:21 pm with the Pro tiem Nurse. Refer to interview on 11/25/15 at 4:28 pm with the Administrator. Interview on 11/25/15 at 4:21 pm with the Pro tiem Nurse revealed: -She was aware that annual infection control training was required for all Medication Aides and Supervisors. -She thought that the nurse that was previously employed with the facility was keeping track of all staff inservices including initial and annual infection control training. -She was not aware there were no trainings on the state-based infection control training. Interview on 11/25/15 at 4:28 pm with the Administrator revealed: -She was aware that annual infection control training was required for all Medication Aides and Supervisors. -The nurse that was previously employed with the facility was responsible for assuring that all MA and Supervisors had their continuing education units including annual infection control training. -She was not aware there were employees that lacked the state-based infection control training. -She did assure all newly hired MA were trained by sending the to the corporate trainings which included the state-based infection control training.	D934		

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