STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014010	A. BUILDING: _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LENOIR	1145 POWELL ROAD NE LENOIR, NC 28645

(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 23-24, 2017.	D 000		
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: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 1 of 5 (#2) sampled residents. (Alendronate.) The findings are: Review of Resident #2's current FL2 dated 7/6/17 revealed: -Diagnoses included seizures, history of venous thrombosis embolism, chronic atrial fibrillation, hypertension, syncope and collapse, and anxiety. -A physician's order for alendronate (used to treat or prevent osteoporosis) 70mg, 1 tablet weekly. Review of Resident #2's physician's order dated 6/20/17 revealed alendronate 70mg once a week on an empty stomach with 8 oz. of water. Review of Resident #2's signed physician order	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014010	A. BUILDING: _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LENOIR	1145 POWELL ROAD NE LENOIR, NC 28645

(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 1	D 358		

sheet dated 8/17/17 revealed alendronate 70mg 1 tablet weekly was renewed.

Interview with Resident #2 on 8/23/17 at 10:30am revealed:
-Her physician had prescribed her a medication to help her with her arthritis "in mid-June."
-"He prescribed a pill to be taken every Thursday."
-"I've only gotten it twice since June."
-"It's to help my bones heal."

Observation of Resident #2's medications on hand in the facility on 8/23/17 at 3:25pm revealed there were no doses of alendronate 70mg tablets available.

Review of Resident #2's July 2017 electronic Medication Administration Record (eMAR) revealed:
-An entry for alendronate 70mg 1 tablet one time a day every Thursday.
-The medication was documented as administered on 7/6/17, 7/13/17, 7/20/17, and 7/27/17.

Review of Resident #2's August 2017 eMAR revealed:
-An entry for alendronate 70mg 1 tablet one time a day every Thursday.
-The medication was documented as administered on 8/3/17, 8/10/17, 8/17/17.
-The next scheduled dose was to occur on 8/24/17.

Telephone interview with the facility's pharmacy provider on 8/23/17 at 3:38pm revealed:
-The current order they had for Resident #2 was alendronate 70mg once a week on Thursday dated 6/20/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014010	A. BUILDING: _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LENOIR	1145 POWELL ROAD NE LENOIR, NC 28645

(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 2	D 358		

-The pharmacy dispensed 4 tablets to the facility for Resident #2 on 6/20/17.
-They had not dispensed any additional alendronate for Resident #2 since 6/20/17.
-"I don't know what the breakdown was with the facility."
-"I don't know why it wasn't on cycle fill."
-"Looks like it should have been sent on a continual basis."

Review of Resident #2's physician's orders, eMARs, and pharmacy dispensing records revealed:
-Nine doses of alendronate 70mg were ordered to be administered from 6/20/17 to 8/17/17.
-According to what the pharmacy dispensed, there would only have been enough alendronate available for 4 out of 9 doses needed.

Interview with a Medication Aide on 8/23/17 at 3:52pm revealed:
-She had administered the last dose of alendronate that was documented for Resident #2 on 8/17/17.
-"I gave the dose last Thursday (8/17/17). It was in a Ziploc bag from our pharmacy."
-The dose administered on 8/17/17 was the last one in the medication cart.
-She had reordered the alendronate after she administered the last dose on 8/17/17.
-"Usually it takes 1 to 2 days" for the medication to be delivered from the facility pharmacy, "but it depends on if the pharmacy has it in stock and if it can get insurance clearance."
-"[Another Medication Aide's name] just ordered it again today."
-The medication should arrive by "tomorrow."
-Resident #2 was scheduled to receive her next dose on 8/24/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014010	A. BUILDING: _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LENOIR	1145 POWELL ROAD NE LENOIR, NC 28645

(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 3 Interview with the Resident Care Coordinator (RCC) on 8/23/17 at 3:55pm revealed: -She could not find Resident #2's June 2017 MAR, but she would keep looking through their files for it. -The facility had paper MAR charting up until 7/5/17. -The facility began using electronic MAR charting on 7/6/17. -Resident #2 received all her medications from the facility pharmacy. -"It's possible [the alendronate] was filled through one of our backup pharmacies." Telephone interview with one of the backup pharmacies used by the facility on 8/23/17 at 4:00pm revealed they had not dispensed any alendronate for Resident #2. Telephone interview with a second backup pharmacy used by the facility on 8/23/17 at 4:07pm revealed they had not dispensed any alendronate for Resident #2. Telephone interview with Resident #2's physician's nurse on 8/24/17 at 8:30pm revealed: -"There was no great urgency for the resident to take the medication (alendronate)." -"Just as long as she starts back on it." -Resident #2's physician "was not alarmed that she had missed doses" of the alendronate. Interview with the Executive Director on 8/24/17 a 12:00pm revealed: -He and his staff had been unable to find a copy of Resident #2's June 2017 MAR. -All the residents' June 2017 MARs on one hallway of the facility could not be located. -His staff had stated they had been administering the alendronate to Resident #2.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014010	A. BUILDING: _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LENOIR	1145 POWELL ROAD NE LENOIR, NC 28645

(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 4 -His staff were unable to explain where the supply had come from they had administered. -He had spoken with the facility pharmacy and they indicated to him they had record of only 4 doses of alendronate had been dispensed for Resident #2 since 6/20/17. -He did not know why the alendronate was not being sent on cycle fill from the pharmacy for Resident #2. -He was going to check with the pharmacy and see if they could start sending it with the cycle fill.	D 358		
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 staff personnel record reviews and interviews, the facility failed to assure 2 of 5 staff sampled (C and E) who had been working for a least a year as Medication Aides (MA) received	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014010	A. BUILDING: _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LENOIR	1145 POWELL ROAD NE LENOIR, NC 28645

(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 5 yearly state approved infection control training. The findings are: A. Review of Staff C's, MA, personnel records revealed: -Staff C was hired on 9/25/15 as a "Resident Assistant (RA)." -Her job title and description changed on 5/15/16 to MA. -Staff C's most recent certificate for state approved infection control training was dated 1/12/16. Interview with the facility Business Office Manager (BOM) on 8/24/17 at 3:40pm revealed: -Staff C's most recent infection control training was on 1/12/16. -An infection control training was held at the facility on 3/14/17, but Staff C missed that training. -She was not aware of a make-up date scheduled for staff that missed the infection control training in March 2017. Refer to the interview with the facility's Health and Wellness Director (HWD), a Registered Nurse, on 8/24/17 at 3:45pm. Refer to the interview with the facility's Executive Director on 8/24/17 at 4:57pm. B. Review of Staff E's, MA, personnel records revealed: -Staff E was hired on 9/16/08 as a MA. -Staff E's most recent certificate for state approved infection control training was dated 1/12/16. Interview with the facility Business Office	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014010	A. BUILDING: _____ B. WING _____	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LENOIR	1145 POWELL ROAD NE LENOIR, NC 28645

(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 6 Manager (BOM) on 8/24/17 at 3:40pm revealed: -Staff E's most recent infection control training was on 1/12/16. -An infection control training was held at the facility on 3/14/17, but Staff E missed that training. -She was not aware of a make-up date scheduled for staff that missed the infection control training in March 2017. Refer to the interview with the facility's Health and Wellness Director (HWD), a Registered Nurse, on 8/24/17 at 3:45pm. Refer to the interview with the facility's Executive Director on 8/24/17 at 4:57pm. _____ Interview with the facility's Health and Wellness Director (HWD) a Registered Nurse, on 8/24/17 at 3:45pm revealed: -She would schedule a make-up infection control training for those staff that missed the March 2017 training. -Under normal circumstances, she would schedule make-up infection control training within 1 month of the missed training. -She had only began working in the facility around the time of the March 2017 training. Interview with the facility's Executive Director on 8/24/17 at 4:57pm revealed: -The facility didn't have a specific policy regarding the yearly state approved infection control training. -All staff complete some infection control training when they are hired that included information on infection prevention and blood borne pathogens.	D934		