Received via electronic mail 03/31/22

The following is a summary of the Plan of Correction for Brookdale NW Greensboro. This Plan of Correction is in regards to the Corrective Action Report dates 2-25-2022. This Plan of Correction is not to be constructed as an admission of or agreement with the findings and conclusions in the State 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, nor have we identified mitigating factors.

10A NCAC 13F .0902(b) Health Care

The facility shall assure referral and follow-up to meet the routine and acute health care needs of the residents.

- The Executive Director (ED)/Health and Wellness Director (HWD)/Health and Wellness Coordinator (HWC) and or designee will conduct retraining and re-education to care associates in regards to referral and follow up of physician's orders. To assist with ongoing compliance, the ED/HWD/HWC or designee will provide weekly monitoring for 3 months and then monthly thereafter for a period of 6 months total. Plan of correction to be completed by April 10th 2022.

10A NCAC 13F. 1004 Medication Administration

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.

- The HWD or designee will rein-service medication aids on the 7 rights of medication administration, to be completed by April 10th 2022. The HWC/HWD or designee will conduct med pass observations on medication aides at a minimum of one per month for 6 months for compliance with the 7 rights of medication administration. To assist with ongoing compliance, the ED/HWD/Resident Care Coordinator (RCC) or designee will follow up on all New Order Tracking forms and review for accuracy and proper transcription of physician orders on a daily basis for one (1) month. Plan of correction to be completed by April 10th 2022.

10A NCAC 13F. 0902 Health Care. 1004 Medication Administration

(j) The resident's medication administration record (MAR) shall be accurate and include the following: 1. Residents name 2. Name of med or treatment order. 3. Strength and dosage or quantity of medication administered. 4. Instructions for administering the medication or treatment. 5. Reason or justification for the administration of the medication or treatment as needed (PRN) and documenting the resulting effect on the resident. 6. Date and time of administration. 7. Documentation of any omission of medications or treatments and the reason for the omission of the medication, including refusals. 8. Name or initials of the person administering the medication or treatment. If initials are

used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

- The ED, HWD, or designee will rein-service medication aids on the rights of medication administration, to be completed by April 10th 2022. The HWC/HWD will conduct med pass observations on medication aides at a minimum of once per month for 6 months to verify for compliance with the rights of medication administration. To assist with ongoing compliance, the ED, HWD, RCC, or designee will review all New Order Tracking forms and review for accuracy and correct transcription of physician orders on a daily basis for one (1) month. Plan of correction to be completed by April 10th 2022.

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

- The ED, HWD and HWC or designee shall rein-service medication aids on the rights of medication administration pursuant to community policy, to be completed by April 10th 2022. To assist with ongoing compliance, the ED/HWD or designee will review New Order Tracking forms for accuracy and correct transcription of physician orders twice weekly for 6 weeks. Plan of correction to be completed by April 10th 2022.

Wendi Bohlinger
Executive Director
Brookdale Northwest Greensboro

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	HAL041031	A. BUILDING: _____ B. WING _____	02/25/2022

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 02/23/22 through 02/25/22.	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: Based on observations, record reviews and interviews, the facility failed to ensure a referral was scheduled for 1 of 5 sampled residents (Resident #5) with an order for a cardiologist appointment for a Halter monitor. The findings are: Review of Resident #5's current FL2 dated 11/09/21 revealed diagnoses included chronic diastolic congestive heart failure, syncope and collapse, anemia, and paroxysmal atrial fibrillation. Review of Resident #5's hospital discharge summary dated 11/08/21 revealed: -Discharge diagnoses included syncope (principal), hypothyroidism, paroxysmal atrial fibrillation, chronic diastolic congestive heart failure, and chronic anemia. -Recommendations for outpatient follow-up included Resident #5 needed to follow up with a cardiologist for a Halter monitor (a portable device for cardiac monitoring). -Resident #5's primary care provider (PCP) signed off on the hospital discharge summary on 11/16/21. -There was a sticky note attached to the hospital	D 273		

Reviewed and acknowledged 03/31/22 Catherine Prater

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D 273	Continued From page 1 discharge summary that read, "Needs cardiology follow-up for Halter monitor. Does she see cardiology already?" Review of Resident #5's PCP visit form dated 11/16/21 revealed an order for a cardiology referral for a Halter monitor. Interview with Resident #5 on 02/24/22 at 12:42pm revealed she did not know anything about a cardiologist appointment or a Halter monitor. Interview with the Executive Director (ED) on 02/24/22 at 11:45am revealed: -The facility relied on Resident #5's PCP office to send referrals to specialists and providers outside of the facility because it was difficult for the facility to get the appointments made. -Resident #5's PCP's office never sent the referral to a cardiologist. -Either the Health and Wellness Director (HWD) or the Health and Wellness Coordinator (HWC) were responsible for following up with Resident #5's PCP regarding the referral to see a cardiologist. -She did not know if the HWD or the HWC followed up with Resident #5's PCP regarding the referral for a cardiologist. Telephone interview with the HWC on 02/25/22 at 11:15am revealed: -When the facility PCP made a referral, the PCP's office contacted the office receiving the referral and faxed the information to the facility. -The office receiving the referral usually called the facility to schedule an appointment for the resident. -The original order for a referral to a cardiologist came from the hospital and was on the hospital	D 273		

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D 273	Continued From page 2 discharge summary dated 11/08/21. -She did not think Resident #5's PCP made a referral to see a cardiologist, but just wrote the referral in her visit notes so that it would be documented. -No cardiology office ever called the facility to schedule an appointment for Resident #5 and she did not know Resident #5 needed a referral to see a cardiologist. -She or the HWD would have been responsible for following up with Resident #5's PCP regarding the referral to a cardiologist, but she did not because she did not know about it. Telephone interview with the referral team supervisor at Resident #5's PCP's office on 02/25/22 at 1:24pm revealed: -The referral team sent out referrals written by the PCP and the office receiving the referral reached out to the facility for follow-up regarding the resident. -Also, the PCP wrote referrals at the facility for the facility to follow up on. -She did not see any mention of a cardiology referral in any of the physician's notes so the order may have been written at the facility for them to follow up. Telephone interview with Resident #5's PCP from a return telephone call on 02/26/22 at 2:43pm revealed: -She wrote the referral for Resident #5 to see a cardiologist at the facility as a reminder for the facility or family to schedule an appointment for Resident #5. -The hospital initiated the referral for Resident #5 to see a cardiologist and she thought the hospital would have reached out to a cardiologist. -She did not know Resident #5 had not been scheduled to see a cardiologist.	D 273		

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D 273	Continued From page 3 -She would have expected the facility to follow up with her regarding the referral to see a cardiologist. Attempted interview with Resident #5's responsible party on 02/25/22 at 9:59am was unsuccessful. The HWD was not available for an interview from 02/23/22 to 02/25/22.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications and provide treatments as ordered for 2 of 5 sampled residents (#4 and #5) with orders for glucose tablets (#4), a diuretic medication, an antihypertensive medication, a potassium supplement, and daily application and removal of thrombo-embolus deterrent (TED) hose (#5). The findings are:	D 358		

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D 358	Continued From page 4 1. Review of Resident #4's current FL2 dated 04/22/21 revealed: -Diagnoses included type 2 diabetes and hypoglycemia (low blood sugar). -Resident #4 was able to make her needs known verbally. -There was an order for fingerstick blood sugar (FSBS) checks four times daily before meals and at bedtime. -There was an order for chewable glucose tablets (used to treat low blood sugar levels), give 3 tablets every 15 minutes as needed (PRN). Review of Resident #4's signed physician orders dated 02/23/22 revealed: -There was an order to check FSBS before meals and at bedtime. -There was an order for chewable glucose tablets, give 3 tablets every 15 minutes as needed for FSBS less than 70, check FSBS 15 minutes after taking and repeat if FSBS is still below 100. Review of Resident #4's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry to monitor FSBS before meals (8:15am, 11:15am, and 4:15pm) and at bedtime (8:00pm). -There was an entry for chewable glucose tablets, give 3 tablets every 15 minutes as needed for FSBS less than 70, check FSBS 15 minutes after taking and repeat if FSBS is still below 100. -FSBS from 01/01/22 through 01/31/22 ranged from 53 through 348. -On 01/20/22 at 8:00pm, FSBS was documented as 61; there was no documentation that glucose tablets were administered. -On 01/29/22 at 11:15am, FSBS was documented as 53; there was no documentation that glucose	D 358		

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D 358	Continued From page 5 tablets were administered. -On 01/30/22 at 8:00pm, FSBS was documented as 69; there was no documentation that glucose tablets were administered. Review of Resident #4's February 2022 eMAR revealed: -There was an entry to monitor FSBS before meals (8:15am, 11:15am, and 4:15pm) and at bedtime (8:00pm). -There was an entry for chewable glucose tablets, give 3 tablets every 15 minutes as needed for FSBS less than 70, check FSBS 15 minutes after taking and repeat if FSBS is still below 100. -FSBS from 02/01/22 to 02/24/22 ranged from 48 to 384. -On 02/01/22 at 4:15pm, FSBS was documented as 62; there was no documentation that glucose tablets were administered. -On 02/07/22 at 4:15pm, FSBS was documented as 66; there was no documentation that glucose tablets were administered. -On 02/18/22 at 11:15am, FSBS was documented as 65; there was no documentation that glucose tablets were administered. -On 02/21/22 at 11:15am, FSBS was documented as 54; there was documentation that glucose tablets were administered at 2:42pm and then documentation that treatment was effective at 3:06pm, with no documentation of a FSBS upon recheck or if the glucose tablets needed to be repeated if the FSBS was still under 100. -On 02/23/22 at 11:15am, FSBS was documented as 65; there was no documentation that glucose tablets were administered. -There was documentation that glucose tablets were administered on 02/23/22 at 6:52pm for a FSBS of 48; there was no documented FSBS check 15 minutes after Resident #4 took the glucose tablets or that glucose tablets were	D 358		

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D 358	Continued From page 6 repeated if the FSBS was still under 100. -FSBS was documented as 82 during the scheduled 8:00pm FSBS check. Interview with Resident #4 on 02/24/22 at 12:50pm revealed: -She was able to tell when her blood sugar was low most of the time because she would feel warm and sweaty. -She was familiar with her sliding scale insulin (SSI) order and that she had an order for glucose tablets if her FSBS got into the 60s or 70s. -The evening prior on 02/23/22, she was not feeling well so asked the medication aide (MA) to check her FSBS. -Her FSBS was 48 so the MA gave her three glucose tablets; when the MA rechecked her FSBS later (she could not remember how long between FSBS checks) it was 82 and was not administered additional glucose tablets. -The MAs always told her what her FSBS reading was, and if it was around 60 or lower, they would give her glucose tablets and sometimes orange juice as well. -The MAs did not always recheck her FSBS after administering the glucose tablets or giving her orange juice. Interview with a MA on 02/24/22 at 1:20pm revealed: -She had checked Resident #4's FSBS on 01/29/22 at 11:15am when it was 53. -Resident #4 had declined her offer to administer glucose tablets because she was on her way to the dining room to eat lunch; she did not document Resident #4's medication refusal and had no reason why. -She had checked Resident #4's FSBS on 02/18/22 at 11:15am when it was 65 and did not administer glucose tablets to her; she could not	D 358		

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D 358	Continued From page 7 remember why. -Resident #4 was alert and oriented and able to tell staff when she was not feeling well or wanted her FSBS checked. -Resident #4 sometimes preferred to eat or drink rather than take the glucose tablets, but she did not document the medication refusal or what Resident #4 consumed instead of the glucose tablets. Interview with a second MA on 02/25/22 at 11:00am revealed: -She had worked on 02/21/22 and checked Resident #4's FSBS when it was 54 at 11:15am before lunch. -She had administered three glucose tablets to her after checking Resident #4's FSBS but did not document it until the end of her shift because she had forgotten to. -She waited until after lunch to recheck Resident #4's FSBS which was then in the 90s. -She did not administer any additional glucose tablets because Resident #4 did not have any symptoms of hypoglycemia and she had eaten lunch. -She did not know the order was to recheck FSBS 15 minutes after administering the glucose tablets or to repeat if FSBS was still under 100. Interview with a third MA on 02/24/22 at 3:00pm revealed: -She had worked the afternoon shift on 02/21/22. -The day shift MA had told her about Resident #4's FSBS being 54 before lunch and that she had administered glucose tablets to her at that time but had not remembered to document it. She told the day shift MA to document that glucose tablets had been administered and she would follow up with Resident #4. -She had rechecked Resident #4's FSBS at the	D 358		

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D 358	Continued From page 8 start of her shift and it "was good" so she did not document the recheck because she needed to check her FSBS before supper anyway. -She could not remember what Resident #4's FSBS was when she rechecked it at the start of her shift. Interview with a fourth MA on 02/24/22 at 3:41pm revealed: -She had worked on 02/07/22 and checked Resident #4's FSBS at 4:15pm when it was 66. -She had not administered glucose tablets to Resident #4 because she had requested a cup of orange juice instead. -She did not document that she offered glucose tablets and Resident #4 had refused. -She had not rechecked Resident #4's FSBS after she drank the orange juice because she was scheduled to check her FSBS at 8:00pm anyway and at 8:00pm her FSBS was 125. -She had worked the afternoon shift on the evening prior (02/23/22). -Resident #4 had requested she check her FSBS because she was worried her blood sugar might be low. -She had checked Resident #4's FSBS at 6:52pm and it was 48 so she administered 3 glucose tablets to her. -She had not rechecked Resident #4's FSBS after 15 minutes of giving her the glucose tablets because Resident #4 was scheduled to have her FSBS checked at 8:00pm. -Resident #4's FSBS at 8:00pm had been 82; she did not administer any additional glucose tablets because Resident #4 had reported to her that she had eaten a snack. She did not document this and had no reason why. Interview with the Health and Wellness Coordinator (HWC) on 02/24/22 at 3:50pm	D 358		

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D 358	Continued From page 9 revealed: -She did not know Resident #4 had FSBS readings less than 70 and was not administered her glucose tablets. -She and the other nurse reviewed the eMARs for accuracy every 3 months. -During eMAR audits she compared the orders in the record to the orders on the eMAR and checked for any consistent medication refusals. -She did not look at each FSBS reading to make sure the MAs were administering medications and "as needed" medications as they were ordered. Telephone interview with a representative from Resident #4's endocrinology office on 02/25/22 at 9:10am revealed: -The endocrinologist was not aware that Resident #4 had been having blood sugars below 70 or that she had not been administered glucose tablets during those episodes. -Adverse reactions to untreated hypoglycemia could include syncope (fainting), falls, or confusion. -The endocrinologist expected MAs at the facility to administer medications as ordered. Interview with the Executive Director (ED) on 02/25/22 at 2:40pm revealed: -She was not aware of the parameters for when Resident #4 was to be administered glucose tablets. -She was not aware that Resident #4's FSBS had been below 70 eight times from 01/01/22 through 02/24/22 and the glucose tablets had only been administered two of those eight times. -She expected the MAs to administer all medications as ordered including doing the FSBS recheck 15 minutes after administering the glucose tablets and then repeating the glucose	D 358		

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D 358	Continued From page 10 tablet dose if Resident #4's FSBS remained under 100. -She expected the HWC to complete eMAR audits monthly and that would include verifying that the orders on the eMAR matched the orders in the record, not specifically checking each FSBS value to verify the glucose tablets were being administered as needed. -All the MAs were trained on caring for diabetic residents and did additional training once per year. -There had been no additional training on reading orders on the eMAR. The HWD was not avilable for interview from 02/23/22 to 02/25/22. 2. Review of Resident #5's current FL2 dated 11/09/21 revealed diagnoses included chronic diastolic congestive heart failure, syncope and collapse, anemia, and paroxysmal atrial fibrillation. a. Review of Resident #5's current FL2 dated 11/09/21 revealed there was an order for metoprolol succinate extended release 25mg 1 tablet daily (used to treat high blood pressure). Review of Resident #5's hospital emergency room (ER) after visit summary dated 12/21/21 revealed: -Resident #5 was seen in the ER due to hypotension, syncope, and hypoxia. -The syncope episode was related to low blood pressures. -Resident #5's beta blocker was decreased by half and her primary care physician (PCP) was to be contacted on 12/22/21. -Take one half (12.5) of the metoprolol daily instead of the full 25mg.	D 358		

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D 358	Continued From page 11 Review of Resident #5's local hospital ER after visit summary dated 12/29/21 revealed an order for metoprolol succinate 25mg tablets 12.5mg daily. Review of Resident #5's quarterly physician's orders dated 02/22/22 revealed an order for metoprolol succinate extended release 25mg one half tablet (12.5mg) daily for hypertension. Review of Resident #5's electronic Medication Administration Record (eMAR) for December 2021 revealed: -There was an entry for metoprolol succinate extended release 25mg 1 tablet daily for hypertension scheduled at 8:00am. -Metoprolol 25mg 1 tablet daily was documented as administered daily 8:00am from 12/01/22 to 12/23/22. -There was an entry for metoprolol succinate extended release 25mg one half tablet (12.5mg) daily for hypertension scheduled at 8:00am. -Metoprolol 25 mg one half tablet daily was documented as administered for 8 out of 9 opportunities from 12/23/21 to 12/31/22. -There was documentation metoprolol 25mg one half tablet was not administered on 12/30/21 due to "waiting to receive from the pharmacy." -Resident #5's systolic blood pressure (SBP) ranged from 105 to 145 and her diastolic blood pressure (DBP) ranged from 67 to 80. Review of Resident #5's eMAR for January 2022 revealed: -There was an entry for metoprolol succinate extended release 25mg one half tablet daily for hypertension scheduled at 8:00am. -Metoprolol 25mg one half tablet daily was documented as administered daily at 8:00am	D 358		

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	HAL041031	A. BUILDING: _____ B. WING _____	02/25/2022

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D 358	Continued From page 12 from 01/01/22 to 01/31/22. -Resident #5's SBP ranged from 101 to 158 and her DBP ranged from 67 to 89. Review of Resident #5's eMAR for February 2022 revealed: -There was an entry for metoprolol succinate extended release 25mg one half tablet daily for hypertension scheduled at 8:00am. -Metoprolol 25mg one half tablet daily was documented as administered daily at 8:00am from 02/01/22 to 02/24/22. -Resident #5's SBP ranged from 122 to 187 and her DBP ranged from 68 to 95. Observation of the medication available for administration to Resident #5 on 02/24/22 at 12:45pm revealed: -Metoprolol Succinate extended release 25mg 1 tablet daily was on the medication cart. -There were whole tablets in the bubble pack -A quantity of 30 whole tablets of metoprolol were dispensed to the facility on 01/24/22 and there were 6 tablets remaining. -There were no one half tablets available for administration. Telephone interview with the pharmacist at the facility's contracted pharmacy on 02/25/22 at 9:40am revealed: -The facility faxed in an order for metoprolol ER 25mg one half tablet daily on 02/24/22 and 30 one half tablets were dispensed to the facility on 02/25/22. -The pharmacy had not received any orders for metoprolol ER 25mg one half tablet prior to 02/24/22. -The previous order was for metoprolol ER 25mg 1 tablet daily and this order was dispensed to the facility on 11/23/21, 12/30, and 01/24/22.	D 358		

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D 358	Continued From page 13 Interview with Resident #5 on 02/24/22 at 12:42pm revealed: -She did not know anything about her medications. -"They give the medicine to me and I take it." -She went to the hospital once because of a fall and could not remember when, but she did not remember why she went to the hospital any other time. -She felt light-headed every once in a while. Interview with a medication aide (MA) on 02/24/22 at 12:51pm revealed: -When she administered metoprolol, she saw metoprolol succinate 25mg on the medication bubble pack and on the eMAR. -She did not check to see if the directions for metoprolol 25mg matched what was labeled on the medication bubble pack and on the eMAR. -She did not know the eMAR documented Resident #5 should be administered one half tablet of metoprolol 25mg and the medication bubble pack was labeled for Resident #5 to be administered 1 tablet of metoprolol 25mg. -If she had realized the directions did not match, she would have contacted the pharmacy to let them know the medication that was dispensed to the facility did not match the medication order on the eMAR. Interview with the Health and Wellness Coordinator (HWC) on 02/24/22 at 3:49pm revealed: -She did not know the order for metoprolol on the eMAR did not match the order for metoprolol that was dispensed from the pharmacy. -The most recent order for metoprolol was 25mg one half tablet daily and the order had not been sent to the pharmacy so they could dispense the	D 358		

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D 358	Continued From page 14 one half tablet. -MAs were responsible for entering the orders on the eMAR and for sending the orders to the pharmacy so the new or updated orders for medication could be dispensed to the facility. -She and the Health and Wellness (HWD) reviewed resident eMARs every 3 months. -She did not know the last time a medication cart audit was completed, but she thought she completed one about 3 months ago. -When she completed a medication cart audit, she made sure there were no expired medications on the cart and that medications matched the orders on the eMAR. Telephone interview with a second MA on 02/5/22 at 11:09am revealed: -She only administered medications to Resident #5 once, but she noticed the order for metoprolol was different on the eMAR than it was on the medication bubble pack. -She did not check for the most recent order for metoprolol in Resident #5's record. -She told the HWC about the different orders and the HWC told her that the order on the bubble pack was correct and to administer the whole table. Telephone interview with the Executive Director (ED) on 02/25/22 at 2:31pm revealed: -She did not know Resident #5 was being administered metoprolol 25mg 1 tablet daily when the latest order was for metoprolol 25mg one half tablet (12.5mg) daily. -She expected the MAs to compare the medication order on the eMAR to the medication bubble pack on the medication cart prior to administration. -The HWD and the HWC were responsible for auditing the medications monthly by comparing	D 358		

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D 358	Continued From page 15 the eMAR and orders in the residents' record. -Someone put the order for metoprolol 25mg one half tablet in Resident #5's record and did not submit the order to the pharmacy. -She expected medication to be administered as ordered. Telephone interview with Resident #5's PCP from a return telephone call on 02/26/22 at 2:43pm revealed: -She thought Resident #5's metoprolol was decreased after a hospital visit due to her having syncope episodes. -She did not know Resident #5 was continuing to be administered metoprolol 25mg daily when the order had been decreased to one half tablet (12.5mg) daily. -Continuing to take metoprolol succinate ER 25mg daily could have resulted in Resident #5's heart rate dropping too low. -She last saw Resident #5 on 02/15/22 due to her reporting light-headedness and weakness. -On 02/15/22, Resident #5's blood pressure was 137/86 and her heart rate was 71 which were "okay." The HWD was not available for an interview from 02/23/22 to 02/25/22. Refer to interview with a medication aide (MA) on 02/23/22 at 3:31pm. Refer to interview with the pharmacist from the facility's pharmacy on 02/23/22 at 3:50pm. Refer to interview with the Executive Director (ED) on 02/24/22 at 1:26pm. b. Review of Resident #5's current FL2 dated 11/09/21 revealed an order for furosemide 20mg	D 358		

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D 358	Continued From page 16 tablets 1 tablet twice a day for congestive heart failure. (a diuretic used to treat swelling and fluid retention.) Review of Resident #5's quarterly physician's orders dated 11/16/21 revealed an order for furosemide 20mg 1 tablet twice daily. Review of Resident #5's quarterly physician's orders dated 02/22/22 revealed an order for furosemide 20mg 1 tablet daily. Review of Resident #5's electronic Medication Administration Record (eMAR) for November 2021 revealed: -There was an entry for furosemide 20mg tablets 1 tablet once daily scheduled for administration at 8:00am. -There was no documentation furosemide was administered on 11/07/21, 11/08/21, 11/09/22, and 11/10/21. -Resident #5's eMAR exception notes dated 11/07/21, 11/08/21, 11/09/21, and 11/11/21 documented furosemide 25mg 1 tablet twice day was not administered due to "needed to be ordered" and "waiting on receive from the pharmacy." -There was no eMAR exception note for 11/10/21 as to why furosemide was not administered to Resident #5. -There was a second entry for furosemide 20mg tablets 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an eMAR note dated 11/11/21 which documented Resident #5 was to be administered furosemide 25mg 1 tablet twice daily and was not administered due to "waiting on receive from the pharmacy." -Furosemide 25mg 1 tablet twice daily at 8:00am and 8:00pm was documented as administered	D 358		

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D 358	Continued From page 17 between 11/11/21 through 11/30/21. Review of Resident #5's eMAR for December 2022 revealed: -There was an entry for furosemide 20mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was no documentation furosemide was administered for on 12/14/21, 12/16/21, 12/17/21, and 12/18/21 at 8:00am and on 12/16/22, 12/18/21, 12/19/21, 12/21/21, and 12/29/21 at 8:00pm. -There was documentation furosemide was not administered due to "pharmacy action required" and "hospitalized." -Resident #5's eMAR exception notes dated 12/16/21, 12/17/21, 12/18/21, and 12/19/21 documented furosemide 20mg 1 tablet twice daily was not administer due to "waiting on pharmacy," "medication pending," and "pending delivery." Review of Resident #5's eMAR for January 2022 revealed: -There was an entry for furosemide 20mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was no documentation furosemide 20mg 1 tablet twice daily was administered on 01/07/22, 01/08/22 and 01/09/22 at 8:00 am due to "pharmacy action required" and on 01/07/22, 01/08/22, 01/09/22, 01/11/22, and 01/31/22 at 8:00pm due to "pharmacy action required." -Resident #5's medication progress notes dated 01/07/21, 01/08/21, and 01/09/21 documented furosemide 20mg 1 tablet twice daily was not administer due to "waiting to receive from pharmacy." Review of Resident #5's eMAR for February 2022 revealed:	D 358		

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D 358	Continued From page 18 -There was an entry for furosemide 20mg 1 tablet twice daily at 8:00am and 8:00pm. -There was no documentation furosemide 20mg 1 tablet daily at 8:00am was administered at 8:00am and 8:00pm on 02/01/22 and there was no documentation why it was not administered. -There was an entry for furosemide 20mg 1 tablet once daily scheduled for administration at 8:00am. -There was documentation furosemide 20mg 1 tablet daily was administered at 8:00am from 02/02/22 to 02/24/22. Observation of the medication available for administration to Resident #5 on 02/24/22 at 12:45pm revealed: -Furosemide 20mg 1 tablet daily was on the medication cart. -A quantity of 30 tablets of furosemide were dispensed to the facility on 02/02/22. Interview with the pharmacist at the facility's contracted pharmacy on 02/24/22 at 11:19am revealed: -Resident #5 had an order for furosemide 20mg 1 tablet daily. -The pharmacy did not have an order for furosemide 20mg 1 tablet twice daily. -Furosemide 20mg 1 tablet daily was dispensed to the facility on 11/02/21, 11/26/21, 12/20/21, 01/13/22, 02/02/22, and 02/23/22 with a quantity of 30 tablets each time. Observation of Resident #5 in her room on 02/23/22 at 8:55am revealed she had moderate swelling in both her legs and feet. Interview with Resident #5 on 02/24/22 at 12:42pm revealed: -She did not know anything about her	D 358		

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D 358	Continued From page 19 medications, and she did not know if the facility ever ran out of any of her medications. -She went to the hospital once because of a fall (She did not remember when.), but she did not remember why she went to the hospital any other time. -She had not noticed swelling in her legs and feet. Interview with a medication aide (MA) on 02/24/22 at 12:51pm revealed: -She did not realize the directions on the eMAR and the medication label on the bubble pack were different for furosemide 20mg tablets. -The eMAR entry was for furosemide 20mg to be administered twice daily and the medication label on the bubble pack was for furosemide to be administered once daily. -She administered furosemide when it popped up on the eMAR to administer, once during her shift. -She did not remember Resident #5 ever being out of furosemide. Interview with the Health and Wellness Coordinator (HWC) on 02/24/22 at 3:49pm revealed: -She did not know the entry for furosemide on the eMAR did not match the order for furosemide that was dispensed from the pharmacy. -She could not find the order where furosemide 20mg changed from 2 tablets daily to 1 tablet daily in November 2021. Telephone interview with a second MA on 02/25/22 at 11:15am revealed: -She did not know the order on the medication bubble pack label and the entry for furosemide on the eMAR were different. -She administered furosemide 20mg 1 tablet daily which was on the medication cart. -She did not remember Resident #5 being out of	D 358		

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D 358	Continued From page 20 furosemide or the order had changed. -The Health and Wellness Director (HWD) and the HWC reviewed medication orders, made changes on the eMAR, and were responsible for medication cart and eMAR audits. Telephone interview with the Executive Director (ED) on 02/25/22 at 2:31pm revealed: -She did not know the order for furosemide 20mg for Resident #5 was for twice daily on the eMAR and once daily on the medication bubble pack label. -She expected the MAs to compare the medication order on the eMAR to the medication bubble pack label on the medication cart prior to administration. -The HWD and the HWC were responsible for auditing the medications monthly by comparing the eMAR and orders in the residents' record. -She expected medication to be administered as ordered. Telephone interview with Resident #5's PCP from a return telephone call on 02/26/22 at 2:43pm revealed: -She was only aware of the order for furosemide 20mg 1 tablet daily for Resident #5. -Resident #5's previous PCP wrote an order for furosemide 20mg daily on a provider note dated 06/09/21 and she wrote an order to continue furosemide 20mg daily on 08/31/21. -She had not seen any orders for furosemide 20mg 1 tablet twice daily and if the order was increased, it must have been increase by another provider or the order was transcribed incorrectly. -She would not have increased the order for furosemide 20mg to twice daily because it could have contributed to low potassium levels for Resident #5. -Resident #5 had lab results from 01/19/21 and	D 358		

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D 358	Continued From page 21 her potassium level and kidney function were within normal limits. -She did not know Resident #5 had missed doses of furosemide due to waiting on the pharmacy. -She expected Resident #5's medication to be administered as ordered. The HWD was not available for an interview from 02/23/22 to 02/25/22. Refer to interview with a medication aide (MA) on 02/23/22 at 3:31pm. Refer to interview with the pharmacist from the facility's pharmacy on 02/23/22 at 3:50pm. Refer to interview with the Executive Director (ED) on 02/24/22 at 1:26pm. c. Review of Resident #5's current FL2 dated 11/09/21 revealed there was no order for thrombo-embolus deterrent (TED) hose (used to treat swelling) on the FL2. Review of Resident #5's primary care provider's (PCP) provider visit form dated 10/05/21 revealed: -Resident #5 had 2+ lower extremity edema with no redness or blisters. -Continue TED hose and furosemide 20mg daily (used to teat swelling). Review of Resident #5's physician's orders dated 11/10/21 revealed an order to apply TED hose every morning and remove every evening. Review of Resident #5's primary care provider's (PCP) visit form dated 02/08/22 revealed Resident #5 had lower extremity edema.	D 358		

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D 358	Continued From page 22 Review of Resident #5's electronic Medication Administration Record (eMAR) for December 2021 revealed: -There was an entry for TED hose apply every morning "and at bedtime" (remove at bedtime) for bilateral edema scheduled for 6:00am and 8:00pm. -There was no documentation TED hose were applied on 12/11/21 at 6:00am due to "TED hose needed to be ordered." -There was no documentation TED hose were removed at 8:00pm on 12/02/21 due to "not wearing," 12/21/21 due to "hospitalization," 12/22/21 due to "not on," and 12/29/21 due to "hospitalization." Review of Resident #5's eMAR for January 2022 revealed: -There was an entry for TED hose apply every morning "and at bedtime" (remove at bedtime) for bilateral edema scheduled for 6:00am and 8:00pm. -There was documentation TED hose were applied at 6:00am from 01/01/22 to 01/31/22. -There was no documentation TED hose were removed at 8:00pm on 01/05/22 due to "not wearing," 01/06/22 due to "not wearing," 01/18/22 due to "not wearing," 01/19/22 (no reason documented), 01/22/22 due to "resident did not have TED hose in room," 01/23/22 due to "resident did not have TED hose in room," 01/24/22 due to "resident did not have TED hose in room," 01/25/22 due to "order to be faxed to pharmacy once measurements were taken and nurses confirmed which TED hose were needed," and 01/27/22 due to "not wearing." Review of Resident #5's eMAR for February 2022 revealed: -There was an entry for TED hose apply every	D 358		

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D 358	Continued From page 23 morning "and at bedtime" (remove at bedtime) for bilateral edema scheduled for 6:00am and 8:00pm. -There was documentation TED hose were applied 8 times from 02/01/22 to 02/08/22 at 6:00am. -There was no documentation TED hose were removed at 8:00pm on 02/01/22 due to "not wearing," 02/02/22 due to "not wearing," 02/03/22 due to "not wearing," and 02/08/22 due to "not wearing." -There was an entry for TED hose apply every morning and remove at bedtime for bilateral edema scheduled for 6:00am and 8:00pm. -There was documentation TED hose were applied 15 times from 02/09/22 to 02/23/22 at 6:00am. -There was no documentation TED hose were removed at 8:00pm on 02/13/22 due to "not on," 02/16/22 due to "not wearing," and 02/23/22 due to "not wearing." Review of Resident #5's Licensed Health Professional Support (LHPS) review dated 02/18/22 revealed: -The LHPS included applying and removing TED hose as a marked task. -Resident #5 had diagnoses of edema, abnormal gait, muscle weakness, and atrial fibrillation. -Resident #5 had 1+ lower extremity edema. -Resident #5's TED hose were applied correctly with no signs of constriction or wrinkles. -The resident did refuse, but staff were to encourage. Observation of Resident #5 on 02/23/22 at 8:55am revealed: -Resident #5 was lying in her bed, and she did not have TED hose on either of her legs. -Both Resident #5's legs and feet were	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041031	A. BUILDING: _____ B. WING _____	02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NORTHWEST GREENSBORO	5809 OLD OAK RIDGE ROAD GREENSBORO, NC 27410

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D 358	Continued From page 24 moderately swollen. Observation of Resident #5 on 02/23/22 at 11:45am revealed: -Resident #5 was sitting in her wheelchair. -She had on bedroom shoes, and she was not wearing TED hose. Observation of the facility on 02/24/22 between 8:02am and 8:20am revealed Resident #5 was sitting in her wheelchair in the front lobby area and she did not have her TED hose on. Interview with the ED on 02/24/22 at 8:22am revealed: -She applied Resident #5's TED hose this morning because she noticed she did not have them on. -Medication aides (MAs) were responsible for applying TED hose to residents, but PCAs sometimes applied them. -She did not know the third shift MA on 02/22/22 and on 02/23/22 documented TED hose had been applied to Resident #5's legs when they had not been. -She expected the third shift MAs to apply Resident #5's TED hose and the second shift MA to remove them. Observation of Resident #5 on 02/24/22 at 12:41pm revealed: -The TED hose on Resident #5's right leg had 2 wrinkles at the right ankle. -The TED hose on Resident #5's left leg had 1 wrinkle at the left ankle. Interview with Resident #5 on 02/24/22 at 12:42pm revealed: -Her TED hose were "normally" not applied in the morning.	D 358		

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D 358	Continued From page 25 -She did not know why someone put them on today, 02/24/22. -She did not refuse to wear her TED hose. -She wore her bedroom slippers all the time and propelled herself independently throughout the hallways in her wheelchair using her feet. -She had not noticed any swelling in her legs or feet. Interview with the pharmacist at the facility's contracted pharmacy on 02/24/22 at 11:19am revealed TED hose were dispensed to the facility on 09/02/21 and 01/25/22. Interview with a first shift MA on 02/24/22 at 12:51pm revealed: -She worked on first shift. -TED hose were to be applied by third shift MAs. -She did not check to see if Resident #5 had on TED hose when she worked because the eMAR did not prompt her to apply them during her shift. Interview with the Health and Wellness Coordinator (HWC) on 02/24/22 at 3:49pm revealed: -The MAs on third shift were responsible for applying Resident #5's TED hose and second shift MAs were responsible for removing them. -She did not know Resident #5's TED hose were documented as being applied when they had not been applied as ordered by the physician. Interview with a second shift MA on 02/24/21 at 4:23pm revealed: -She worked on second shift and second shift MAs were responsible for removing Resident #5's TED hose. -Resident #5 usually did not have her TED hose on when she started her shift. -She reordered TED hose in January 2022	D 358		

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BROOKDALE NORTHWEST GREENSBORO	5800 OLD OAK RIDGE ROAD GREENSBORO, NC 27410

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D 358	Continued From page 26 because staff could not find them. Telephone interview with a third shift MA on 02/25/22 at 8:18am revealed: -Third shift MAs were responsible for applying Resident #5's TED hose and documenting the TED hose had been applied. -She accidentally documented Resident #5's TED hose were applied on 02/23/22, but they were not applied. -On 02/23/22, she went to assist a personal care aide (PCA) with personal care for a different resident and she forgot to apply TED hose to Resident #5's legs. -Resident #5 never told her she did not like to put her TED hose on or refused to have TED hose applied. -She did not know if Resident #5's TED hose had ever been lost or misplaced. Telephone interview with Resident #5's PCP from a return telephone call on 02/26/22 at 2:43pm revealed: -Resident #5 had an order for TED hose to be applied in the morning and removed in the evening due to swelling in her legs. -She observed Resident #5's TED hose to be applied sporadically from visit to visit. -She saw Resident #5 in November 2021 and documented she was not wearing TED hose, and she documented Resident #5 was wearing TED hose in January 2022. -Resident #5 continued to have swelling in her legs and she expected TED hose to be applied daily. -If Resident #5's TED hose were not applied, she would rather staff document that they were not applied. -If Resident #5's TED hose were not applied daily as ordered, she could have increased swelling,	D 358		

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D 358	Continued From page 27 pain, and discomfort in her legs. The HWD was not available for an interview from 02/23/22 to 02/25/22. Refer to interview with a medication aide (MA) on 02/23/22 at 3:31pm. Refer to interview with the pharmacist from the facility's pharmacy on 02/23/22 at 3:50pm. Refer to interview with the Executive Director (ED) on 02/24/22 at 1:26pm. Interview with a MA on 02/23/22 at 3:31pm revealed: -MAs were responsible for reviewing new medication and treatment orders and entering them onto the eMAR. -Any MA who walked in the medication room and saw a faxed medication/treatment order on the fax machine was to enter the medication/treatment order on the eMAR, complete a new order form, put the form on the facility nurse's desk, and fax the order to the pharmacy. -One of the facility nurses was responsible for reviewing the new medication/treatment order and for making sure it was entered correctly on the eMAR by the MA. Interview with the pharmacist from the facility's pharmacy on 02/23/22 at 3:50pm revealed: -The facility entered their own orders onto the eMAR. -It was the facility's responsibility to send the order to the pharmacy after they entered it on the eMAR. -If the facility did not send an order for a medication/treatment, the medication was not	D 358		

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D 358	Continued From page 28 dispensed and the treatment was not provided to the facility. Interview with the ED on 02/24/22 at 1:26pm revealed: -MAs, the HWD, and the HWC were responsible for processing new physician's orders. -New orders should be entered into the eMAR system by the MA, the HWD, or the HWC and a copy of the physician's order should be sent to the pharmacy. -If a MA entered the order on the eMAR, a new order form should be completed and put in a file for the HWD or HWC to check once entered. -If the new physician's order was complicated, it should be placed on the HWD's or the HWC's desk to process. The facility failed to ensure medications and treatments were administered as ordered for 2 of 5 sampled residents including a resident who had low fingerstick blood sugar readings and was not administered glucose tablets which could have resulted in fainting, falls, or confusion (#4); a resident who was administered a whole tablet of metoprolol 25mg instead of one half tablet (12.5mg) as ordered including missed doses which could have resulted in the resident's heart rate dropping too low, and the resident did not have her TED hose applied and removed daily as ordered resulting in swelling in her lower legs (#5). This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of correction in accordance with G.S. 131D-34 on 02/24/22 for this violation. CORRECTION DATE FOR THE TYPE B	D 358		

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D 358	Continued From page 29 VIOLATION SHALL NOT EXCEED, APRIL 11, 2022.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure medication administration records were complete and accurate for 1 of 6 sampled resident (#6) with an order for an anxiety medication. The findings are: Review of Resident #6's current FL2 dated	D 367		

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D 367	Continued From page 30 08/22/21 revealed diagnoses included hypertension, coronary artery disease and paroxysmal tachycardia. Review of Resident #6's physician's orders dated 02/22/22 revealed an order for Lorazepam tablet 0.5mg give 1 tablet two times a day for anxiety. Review of Resident #6's record revealed: -There was an electronic order dated 01/21/22 for Lorazepam 0.5mg tablet give 1/2 tablet (0.25mg) orally twice a day. -There was a verbal order dated 01/24/22 and signed by the PCP on 02/01/22 for Lorazepam 0.5mg tablet orally one tablet twice a day. -There was an electronic order dated 02/16/22 for Lorazepam 0.5mg tablet give 1/2 tablet (0.25mg) tablet orally twice a day. Review of Resident #6's January 2022 eMAR revealed: -There was an entry for Lorazepam 0.5mg tablet give one half tablet orally twice a day beginning on 01/21/22. -Lorazepam 0.5mg tablet one half tablet was documented as administered two times a day at 8:00am and 8:00pm from 01/21/22 through 01/24/22. -There was an entry for Lorazepam 0.5mg tablet give 1 tablet orally twice a day beginning on 01/24/22. -Lorazepam 0.5mg 1 tablet was documented as administered two times a day at 8:00am and 8:00pm from 01/24/22 through 01/31/22. Review of Resident #6's February 2022 eMAR revealed: -There was an entry for Lorazepam 0.5mg tablet give 1 tablet orally twice a day. -Lorazepam 0.5mg tablet 1 tablet was	D 367		

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D 367	Continued From page 31 documented as administered two times a day at 8:00am and 8:00pm from 02/01/22 through 02/24/22. Observation of Resident #6's medication on hand 02/24/22 at 8:05am revealed a bubble card labeled Lorazepam 0.5mg take one half tablet (0.25mg) twice a day for a quantity of 60 tablets dispensed on 2/16/22 with 58 tablets remaining. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/24/22 at 11:21am revealed: -There was an electronic order for Resident #6's lorazepam 0.5mg take on half tablet twice a day dated 01/21/22 and 02/16/22 from the Resident #6's primary care provider (PCP). -Lorazepam 0.5mg give one half tablet (0.25mg) for a quantity of 60 tablets was dispensed on 01/21/22 and on 02/16/22. -The pharmacy had never received an order for lorazepam 0.5mg take 1 tablet twice a day for Resident #6 and never dispensed lorazepam 0.5mg 1 tablet twice daily for Resident #6. -There was no record that lorazepam 0.5mg give 1 tablet twice a day was returned to the pharmacy by the facility for Resident #6. -The pharmacy kept medication profiles for the facility but did not enter the facility's orders on the eMAR. -Facility staff entered the orders on the eMAR and faxed the orders to pharmacy to be added to the residents' profiles. -The pharmacy was not able to access and see the facility's eMAR and did not compare residents' orders to the eMAR. Interview with Resident #6 on 02/24/22 at 12:00pm revealed: -He could not remember all of his medications he	D 367		

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D 367	Continued From page 32 took. -He knew he had an anxiety medication he took two times a day. -He began taking the anxiety medication last month (January 2022) when his spouse, who resided at the facility with him, had to be transferred to another facility for a while. Interview with a medication aide (MA) on 02/24/22 at 10:35am revealed: -She knew Resident #6's lorazepam was one half tablet twice a day. -She did not routinely compare the medication bubble card label to the eMAR because he had lorazepam 0.5mg one half tablet twice a day for anxiety since January 2022 when his spouse was transferred to a rehabilitation facility. -She had not noticed the eMAR entry for lorazepam was for 0.5mg 1 tablet twice a day until the surveyor brought it to her attention. -She did not know he had an order on 01/24/22 for lorazepam 0.5mg give 1 tablet twice a day. -Either the MA or the Health and Wellness Coordinator (HWC) entered the orders on the eMAR and then faxed the orders to the pharmacy. -When the medication bubble cards were delivered from the pharmacy, the MA compared the labels on the medication bubble cards to the manifesto the delivery person had and not to the eMAR orders. Interview with the HWC on 02/24/22 at 10:50am revealed: -She was responsible to audit orders and medication carts to ensure all orders and medications were accurate and remove expired or discontinued medications. -Medications that were delivered by the contracted pharmacy should be checked and	D 367		

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D 367	Continued From page 33	D 367		

matched to the order on the eMAR.
-She and another nurse reviewed eMARs for accuracy every 3 months.
-When she audited eMARs and medication carts, she looked for orders to match from the resident's records, eMAR entries and medication bubble cards on the medication carts.
-She had not performed a medication cart or eMAR audit for 3 months and had not assigned anyone to perform the cart audits.
-Third shift would normally perform medication cart audits, but they have had many agency staff MAs who were not accustomed to performing medication cart audits.
-She or the MAs entered orders in the eMAR, whomever received the order was responsible to enter that order.
-Orders entered by MAs were left in the file bin for nurses to review.
-She entered a verbal order taken from the PCP on 01/24/22 on Resident #6's eMAR for lorazepam 0.5mg take 1 tablet two times a day.
-She faxed the order to the contracted pharmacy because there was another order for a medication written on the verbal order page.
-Pharmacy must have a prescription directly from the provider for controlled substances such as Resident #6's lorazepam.
-The PCP must not have sent the electronic order for Resident #6's lorazepam 0.5mg give 1 tablet twice a day after she spoke with the pharmacy on 01/24/22.

Telephone interview with Resident #5's PCP from a return telephone call on 02/28/22 at 2:55pm revealed:
-Resident #6 was given an order for lorazepam 0.5mg one half tablet (0.25mg) twice a day on 01/21/22.
-She did not have an order dated 01/24/22 for the

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D 358	Continued From page 26 because staff could not find them. Telephone interview with a third shift MA on 02/25/22 at 8:18am revealed: -Third shift MAs were responsible for applying Resident #5's TED hose and documenting the TED hose had been applied. -She accidentally documented Resident #5's TED hose were applied on 02/23/22, but they were not applied. -On 02/23/22, she went to assist a personal care aide (PCA) with personal care for a different resident and she forgot to apply TED hose to Resident #5's legs. -Resident #5 never told her she did not like to put her TED hose on or refused to have TED hose applied. -She did not know if Resident #5's TED hose had ever been lost or misplaced. Telephone interview with Resident #5's PCP from a return telephone call on 02/26/22 at 2:43pm revealed: -Resident #5 had an order for TED hose to be applied in the morning and removed in the evening due to swelling in her legs. -She observed Resident #5's TED hose to be applied sporadically from visit to visit. -She saw Resident #5 in November 2021 and documented she was not wearing TED hose, and she documented Resident #5 was wearing TED hose in January 2022. -Resident #5 continued to have swelling in her legs and she expected TED hose to be applied daily. -If Resident #5's TED hose were not applied, she would rather staff document that they were not applied. -If Resident #5's TED hose were not applied daily as ordered, she could have increased swelling,	D 358		

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D 358	Continued From page 27 pain, and discomfort in her legs. The HWD was not available for an interview from 02/23/22 to 02/25/22. Refer to interview with a medication aide (MA) on 02/23/22 at 3:31pm. Refer to interview with the pharmacist from the facility's pharmacy on 02/23/22 at 3:50pm. Refer to interview with the Executive Director (ED) on 02/24/22 at 1:26pm. Interview with a MA on 02/23/22 at 3:31pm revealed: -MAs were responsible for reviewing new medication and treatment orders and entering them onto the eMAR. -Any MA who walked in the medication room and saw a faxed medication/treatment order on the fax machine was to enter the medication/treatment order on the eMAR, complete a new order form, put the form on the facility nurse's desk, and fax the order to the pharmacy. -One of the facility nurses was responsible for reviewing the new medication/treatment order and for making sure it was entered correctly on the eMAR by the MA. Interview with the pharmacist from the facility's pharmacy on 02/23/22 at 3:50pm revealed: -The facility entered their own orders onto the eMAR. -It was the facility's responsibility to send the order to the pharmacy after they entered it on the eMAR. -If the facility did not send an order for a medication/treatment, the medication was not	D 358		

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	HAL041031	A. BUILDING: _____ B. WING _____	02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NORTHWEST GREENSBORO	5809 OLD OAK RIDGE ROAD GREENSBORO, NC 27410

(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 367	Continued From page 34 resident to receive a whole tablet (0.5mg). -She did not recall giving a verbal order on 01/24/22 or signing a verbal order on 02/1/22 for lorazepam 0.5mg 1 tablet twice a day, but may have overlooked it if it had other orders written with it. -She would have had to send an electronic order to the pharmacy because lorazepam was a controlled substance. -She thought the HWC transcribed the order incorrectly and entered the order incorrectly on the eMAR. -She had not been contacted by any staff at the facility or the facility's contracted pharmacy to verify Resident #6's order for lorazepam. -She expected the facility to process and administer Resident #6's lorazepam as ordered. -She was not concerned if he had received 0.5mg instead of 0.25mg two times a day because it would not have been a big difference in the dosage. -If he received too much lorazepam he could have confusion and appear over sedated. -She had not received any report from the facility of Resident #6 appearing over sedated during the past two months. Telephone interview with the Executive Director (ED) on 02/25/22 at 2:40pm revealed: -She was aware that Resident #6 had an order for lorazepam 0.5mg give one half tablet twice a day. -She was not aware there was an entry on the eMAR for lorazepam 0.5mg give 1 tablet twice a day. -The MAs entered orders in the eMAR system as they were written or faxed and the orders were left for the nurses to review. -She expected the MAs to administer all medications as ordered and to compare the	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041031	A. BUILDING: _____ B. WING _____	02/25/2022

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D 367	Continued From page 35 medication to the eMAR. -She expected the HWC to complete eMAR audits monthly and that would include verifying that the orders on the eMAR matched the orders in the record. -She was not sure if eMAR audits had been performed since January 2022. -The HWC must have entered the lorazepam order incorrectly on the eMAR. The HWD was not available for interview from 02/23/22 to 02/25/22.	D 367		
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 observations, interviews and record reviews, the facility failed to ensure 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 administer medications and provide treatments as ordered for 2 of 5 sampled residents (#4 and #5) with orders for glucose tablets (#4), a diuretic medication, an antihypertensive medication, a	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 36 potassium supplement, and daily application and removal of thrombo-embolus deterant (TED) hose (#5). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		