STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	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 A follow up survey was conducted by the Adult Care Licensure Section on May 12-13, 2022.	{D 000}		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Follow-Up to Type A2 Violation. The Type A2 Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents (#2) who had orders for weekly weights. The findings are: Review of Resident #2's current FL-2 dated 01/25/22 revealed diagnoses included essential hypertension, major depression, Type II Diabetes and acute bronchitis. Review of a signed physician's order dated 02/17/22 revealed: -There was an order for weekly weights. -There was an order for Lasix 10mg daily for edema. (Lasix is a medication used to treat fluid	{D 276}		

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{D 276}	Continued From page 1 retention). Review of Resident #2's signed physician's orders dated 03/17/22 revealed there was an order for weekly weights to be obtained every Friday on day shift. Review of a Consult Pharmacist Note for Resident #2 dated 04/26/22 revealed there was documentation that weights should be obtained weekly. Review of Resident #2's March 2022 electronic medication administration record (eMAR) revealed there was no entry for weekly weights. Review of Resident #2's April 2022 eMAR revealed there was no entry for weekly weights. Review of Resident #2's May 2022 eMAR revealed there was no entry for weekly weights. Interview with the Health and Wellness Coordinator on 05/13/22 at 1:55pm revealed: -Resident #2 had an order for weekly weights due every Friday on day shift. -The order for weekly weights was entered into the system incorrectly and the order did not populate on the electronic medication administration record (eMAR). -She was not aware that Resident #2's weekly weights were not on the EMAR. -It was the responsibility of the supervisor to enter orders into the EMAR system. -It was the responsibility of the Health and Wellness Director (HWD) to ensure that the weekly weights were completed. -The HWD position was currently vacant and she was not sure who was responsible for reviewing weights.	{D 276}		

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{D 276}	Continued From page 2 Interview with the Administrator on 05/13/22 at 2:19pm revealed it was the responsibility of the medication aides (MA) to implement procedures as ordered by the PCP. Attempted telephone interview with Resident #2's primary care provider (PCP) on 05/13/22 at 11:50am was unsuccessful.	{D 276}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents (#1, #6) observed during the medication pass including errors related to a blood pressure medication not being administered (#1) and late administrations of pain medications (#6.) The findings are: 1. The medication error rate was 9% as evidence by the observation of 3 errors out of 32 opportunities during the 8:00am medication pass on 05/12/22 and 05/13/22.	{D 358}		

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{D 358}	Continued From page 3 a. Review of Resident #1's current FL-2 dated 03/17/22 revealed: -Diagnoses included hypothyroidism, gastroesophageal reflux disease (GERD), dementia without behavioral disturbances and osteoporosis. -There was an order for Propranolol 20mg twice a day. (Propranolol is used to lower the blood pressure.) Observation of the 8:00am medication pass on 05/13/22 revealed: -The medication aide (MA) checked Resident #1's blood pressure and documented the results of 178/75 and heart rate of 68 on the electronic medication administration record (eMAR.) -The MA prepared and administered 7 ½ pills to Resident #1 at 8:00am. -The MA did not administer Resident #1's Propranolol 20mg. Observation of Resident #1's medication on hand on 05/13/22 revealed there was 1 of 56 tablet of Propranolol 20mg that remained. Review of Resident #1's May 2022 eMAR revealed: -There was an entry for Propranolol 20mg twice a day scheduled at 8:00am and 8:00pm with instructions to hold medication if the systolic blood pressure (SBP) was less than or equal to 100 or heart rate was less than or equal to 55. -Propranolol was documented as administered on 01/13/22 at 8:00am. Interview with the MA on 05/13/22 at 10:59am revealed: -She did not administer Resident #1's Propranolol. -She checked each resident's eMAR and	{D 358}		

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{D 358}	Continued From page 4	{D 358}		

compared it against the medications on hand for accuracy prior to administration.
-The MAs documented their initials and the date on the medication bubble pack after the medication was popped out.
-Her initials or the date (05/13/22) were not on Resident #1's Propranolol.
-It was the responsibility of the MA to notify the Health and Wellness Director and the primary care provider (PCP) for medication errors.

Interview with Health and Wellness Coordinator (HWC) on 05/13/22 at 11:20am revealed the MA should notify the resident's primary care provider (PCP) if medications were not administered as ordered.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 05/13/22 at 11:50am was unsuccessful.

Based on observations, record reviews, and interviews, it was determined that Resident #1 was not interviewable.

2. Review of Resident #6's current FL-2 dated 07/13/21 revealed diagnoses included essential hypertension, lower back pain and osteoarthritis.

a. Review of Resident #6's signed physician's orders dated 03/17/22 revealed there was an order for Acetaminophen 500mg two tablets three times a day for pain. (Acetaminophen is used to treat minor aches and pains.)

Observation of the 8:00am medication pass on 05/12/22 revealed Acetaminophen 500mg two tablets.

Review of Resident #6's May 2022 electronic

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{D 358}	Continued From page 5	{D 358}		

medication administration record (eMAR) revealed:
-There was an entry for Acetaminophen 500mg two tablets three times a day scheduled at 8:00am, 2:00pm and 8:00pm.
-Acetaminophen was documented as administered on 05/12/22 for the 8:00am entry.

b. Review of Resident #6's signed physician's orders dated 03/17/22 revealed there was an order for Gabapentin 100mg three times a day. (Gabapentin is used to treat seizures and nerve pain.)

Observation of the 8:00am medication pass on 05/12/22 revealed Gabapentin 100mg were administered to Resident #6 at 10:10am.

Review of Resident #6's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Gabapentin 100mg three times a day scheduled at 8:00am, 2:00pm and 8:00pm.
-Gabapentin 100mg was documented as administered on 05/12/22 for the 8:00am entry.

Interview with the MA on 05/12/22 at 1:10pm revealed it was the responsibility of the MA to administer medications within an hour before or an hour after scheduled administration times.

Attempted telephone interview with Resident #6's primary care provider (PCP) on 05/13/22 at 11:50am was unsuccessful.

Based on observations, record reviews, and interviews, it was determined that Resident #6 was not interviewable.

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{D 358}	Continued From page 6 Refer to Interview with Health and Wellness Coordinator (HWC) on 05/13/22 at 11:20am. Refer to Interview with the Administrator on 05/12/22 at 1:15pm. _____ Interview with Health and Wellness Coordinator (HWC) on 05/13/22 at 11:20am revealed -Medications should be administered within an hour before or an hour after the scheduled administration time. -The medication aides (MA) should notify the resident's primary care provider (PCP) if medications were not administered as ordered. Interview with the Administrator on 05/12/22 at 1:15pm revealed: -Medications should be administered within an hour before or an hour after the scheduled administration time. -She was not aware of any concerns from residents related to receiving medications late.	{D 358}		
{D935}	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction	{D935}		

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{D935}	Continued From page 7 in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure 2 of 3 sampled staff (Staff B and C) who administered medications had completed the medication aide training and competency evaluation before administering medications including Staff C who did not complete the 5, 10, or 15 hour medication aide training course and the clinical skills checklist, and Staff B who did not complete the clinical skills checklist.	{D935}		

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{D935}	Continued From page 8 The findings are: 1. Review of Staff C's, medication aide (MA) personnel record revealed: -Staff C was hired on 10/26/21. -There was documentation she Staff C passed the written MA exam on 01/13/17. a. Review of Staff B's personnel record revealed there was no documentation she completed the 5/10- and 15-hour medication aide training on 11/23/21. Interview with the Administrator on 05/13/22 at 10:32pm revealed: -She did not know Staff C did not have the certificate for the 15-hour state approved medication administration training course for MAs. -She thought the previous Health Wellness Director (HWD) had completed the training prior to her leaving employment at the facility. -She thought all the required documents related to MA training were completed. -The HWD was responsible for ensuring MAs had completed the 15-hour state approved medication administration training course and medication aide clinical skills validation. Second interview with the Administrator on 05/13/22 at 2:19pm revealed the BOM was responsible for giving the MA staff records to the HWD to complete the 5/10/15 hour MA training. Interview with the Business Office Manager (BOM) on 05/13/22 at 2:19pm revealed she was aware the MAs were required to complete the 5/10/15 hour MA training prior to administering medications.	{D935}		

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{D935}	Continued From page 9 b. Review of Staff C's personnel record revealed there was documentation Staff B completed a medication clinical skills competency validation on 11/17/21 at another facility. Interview with the Business Office Manager (BOM) on 05/13/22 at 2:19pm revealed: -It was the responsibility for the Health and Wellness Director (HWD) to complete the clinical skills validation checklist for the medication aides (MA). -The HWD completed some of the MAs clinical skills checklist that were due but did not complete all of them. -She did not know the facility could not use a medication clinical skills validation completed by another facility. Interview with the Administrator on 05/13/22 at 2:19pm revealed: -She was aware in February 2022 that Staff C did not have the mandatory clinical skills checklist completed. -The BOM was responsible for giving the MA staff records to the HWD to complete the clinical skills validation checklist. -The HWD completed some of the MAs clinical skills checklist but not all prior to leaving the company on 05/02/22. -It was the responsibility of the HWD to complete the clinical skills checklist for the MA. -She was not aware that the clinical skills validation checklist was not transferrerable between facilities. -She did not know the agency MAs needed to have their medication aide clinical skills validated by a nurse at the facility prior to administering medications. Review of two residents March 2022 electronic	{D935}		

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{D935}	Continued From page 10	{D935}		

medication administration records (eMARs) revealed Staff C administered medications on 03/04/22, 03/07/22, and 03/14/22.

Review of two residents April 2022 eMARs revealed Staff C documented administering medications on 04/04/22, 04/11/22, 04/13/22, 04/14/22, 04/19/22, 04/20/22, 04/25/22, and 04/28/22.

Review of two residents May 2022 eMAR revealed Staff C documented administering medications on 05/04/22 and 05/12/22.

Refer to interview with the Business Office Manager (BOM) on 05/13/22 at 2:19pm.

Refer to interview with the Administrator on 05/13/22 at 2:19pm.

2. Review of Staff B's, MA personnel record revealed:
-There was no hire date documented for Staff B.
-There was documentation he passed the written MA exam on 11/02/21.
-There was documentation Staff B completed a medication clinical skills competency validation on 11/17/21 at another facility.

Interview with Staff B on 05/13/22 at 7:50am revealed:
-He had been working at the facility for about six months.
-He worked for a staffing agency.
-His training included a skills checkoff with the HWD.
-The agency contracted with "someone" for training.
-The agency sent training records to the facility.

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{D935}	Continued From page 11 Interview with the Business Office Manager (BOM) on 05/13/22 at 2:19pm revealed: -She was aware the MAs were required to complete the clinical skills validation checklist prior to administering medications. -It was the responsibility for the Health and Wellness Director (HWD) to complete the clinical skills validation checklist for the medication aides (MA). -The HWD completed some of the MAs clinical skills checklist that were due but did not complete all of them. -She did not know the facility could not use a medication clinical skills validation completed by another facility. Interview with the Administrator on 05/13/22 at 2:19pm revealed -The BOM was responsible for giving the MA staff records to the HWD to complete the clinical skills validation checklist. -The HWD completed some of the MAs clinical skills checklist but not all prior to leaving the company on 05/02/22. -It was the responsibility of the HWD to complete the clinical skills checklist for the MA. -She was not aware that the clinical skills validation checklist was not transferrerable between facilities. -She did not know the agency MAs needed to have their medication aide clinical skills validated by a nurse at the facility prior to administering medications. Review of two residents March 2022 eMARs revealed Staff B documented administering medications on 03/11/22, 03/24/22, and 03/28/22. Review of two residents April 2022 eMARs revealed Staff B documented administering	{D935}		

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{D935}	Continued From page 12 medications on 04/01/22, 04/08/22, 04/21/22, 04/23/22, 04/24/22, 04/26/22, and 04/28/22. Review of two residents May 2022 eMAR revealed Staff B documented administering medications on 05/01/22, 05/05/22, 05/06/22, 05/07/22 and 05/10/22. Refer to interview with the BOM on 05/13/22 at 2:19pm. Refer to interview with the Administrator on 05/13/22 at 2:19pm. _____ Interview with the Business Office Manager (BOM) on 05/13/22 at 2:19pm revealed: -The BOM utilized a spreadsheet to track employees' training and other requirements to ensure compliance. -She was aware the MAs required the 5/10/15 hour MA training and clinical skills validation to be completed prior to administering medications. Interview with the Administrator on 05/13/22 at 2:19pm revealed: -The HWD completed some of the MAs clinical skills checklist but not all prior to leaving the company on 05/02/22. -It was the responsibility of the HWD to complete the clinical skills checklist for the MA. -It was the responsibility of the HWD and the BOM to ensure the appropriate staff training was completed and the personnel records were up to date. -It was the responsibility of the Administrator to oversee and ensure that staff personnel records were up to date. -It was the responsibility of the Administrator to audit staff personnel records monthly.	{D935}		

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{D935}	Continued From page 13 Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration.	{D935}		