STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032019	A. BUILDING: _____ B. WING _____	02/28/2024

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BROOKDALE CHAPEL HILL	2230 FARMINGTON DRIVE CHAPEL HILL, NC 27514

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey with an exit date of February 28, 2024.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure staff administered medications had successfully completed the state-approved 5-hour, 10-hour or 15-hour medication aide (MA) training courses as required prior to administering medications for 1 of 3 sampled staff (Staff A). The findings are: Review of Staff A's, Medication Aide (MA), personnel record revealed: -She was hired on 06/26/17. -There was documentation Staff A completed the 10-hour MA training on 12/18/18. -There was documentation of a clinical skills checklist completed on 11/1/21. -There was no documentation that Staff A completed the 5-hour MA training.	D 125	(1) Staff A remains off the schedule as a Medication Aide until the 5 hour ~~Infection~~ MED TECH ~~Control~~ course has been completed by Staff A. 4/15/24 (2) Retraining conducted by the Executive Director with the business office coordinator on medication Aide requirements. 4/15/24 (3) The business office coordinator or designee will complete an audit of current medication Aide files for completion of medication Aide training requirements by 4/1/24. 4/1/24	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Executive Director 04/02/2024

Reviewed and acknowledged 04/08/24 kc

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D 125	Continued From page 1 Review of resident's December 2023, January 2024, and February 1 through 27, 2024 electronic medication administration (eMAR) records revealed: -There was documentation that Staff A administered medications to residents on the first shift on 12/01/23, 12/05/23, 12/06/23, 12/07/23, 12/09/23, 12/10/23, 12/12/23, 12/13/23, 12/14/23, 12/18/23, 12/19/23, 12/20/23, 12/21/23, 12/23/23, 12/24/23, 12/25/23, 12/27/23, 12/28/23, and 12/29/23. -There was documentation that Staff A administered medications to residents on the first shift on 01/01/24, 01/02/24, 01/03/24, 01/06/24, 01/07/24, 01/09/24, 01/10/24, 01/11/24, 01/12/24, 01/15/24, 01/16/24, 01/17/24, 01/20/24, 01/21/24, 01/23/24, 01/24/24, 01/25/24, 01/26/24, 01/29/24, 01/30/24, and 01/30/24. -There was documentation that Staff A administered medications to residents on the first shift on 2/3/24, 2/4/24, 2/6/24, 2/7/24, 2/8/24, 2/9/24, 2/13/24, 2/14/24, 2/15/24, 2/17/24, 2/18/24, 2/20/24, 2/21/24, 2/22/24, 2/23/24, and 2/27/24. Interview with Staff A on 02/28/24 at 2:45pm revealed: -She worked as a MA prior to starting work at the facility. -She did not know what MA training she completed; she did not know what the 5-hour and 10-hour training consisted of. -She had no documented evidence she completed the 5-hour MA training. -She administered medications to residents full-time. Interview with the Executive Director on 02/28/24 at -He was unaware Staff A had not completed the	D 125	(4) TO ASSIST WITH ONGOING COMPLIANCE, THE DSC, ED, AED OR DESIGNEE WILL CONDUCT AN AUDIT OF THE MEDICATION ADMINISTRATION TRAINING RECORDS WEEKLY FOR TWO MONTHS. THE RESULTS OF THE AUDITS WILL BE PRESENTED IN QI MEETING FOR REVIEW AND ANALYSIS BY THE ED OR DESIGNEE.	6/1/24

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D 125	Continued From page 2 5-hour state approved required MA training. -Staff A administered medications to residents. -The Business Office Coordinator (BOC) was responsible to ensure staff personnel records were updated with the required documentation. Interview with the BOC on 02/28/24 at 2:30pm revealed: -She was responsible for the staff personnel records. -She did not complete audits to ensure the personnel records were complete.	D 125		
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, record reviews and interviews, the facility failed to administer medication as ordered for 2 of 4 residents observed during the morning medication pass who had orders for a cholesterol lowering medication (#7) and a vitamin supplement (#6); and for 1 of 5 sampled residents for record review (#5) who had an order for an as needed (PRN) rectal medication used to treat seizures. The findings are:	D 358	(1) The Medication Aide will complete re-training with the Health & Wellness Director and pass the NC Medication Aide course no later than 3/27/24. Unable to retroactively correct medication error for Rosuvastatin 40mg, Ocuvite with Lutein and Diazepam for residents #5, #6, and #7. POP and report filed on 2/29/24.	3/27/24

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D 358	Continued From page 3 1. The medication error rate was 7% as evidenced by 2 errors out of 27 opportunities during the 8:00am medication pass on 02/28/24. a. Review of Resident #6's current FL2 dated 01/08/24 revealed diagnoses included dementia with underlying disease, congestive heart failure and macular degeneration. Review of Resident #6's current FL2 dated 02/01/24 revealed there was an order for Cerovite with Lutein tablet (a multi-vitamin supplement) once daily. Observation of the morning medication pass on 02/28/24 at 8:04am revealed: -The medication aide (MA) removed 7 oral medications (one medication was ordered for 2 tablets per dose) from the medication cart and compared each medication label to the medications displayed on the electronic medication administration record (eMAR). -The MA administered 8 tablets with water to Resident #6. -There was no Cerovite with Lutein tablet administered to Resident #6. Review of Resident #6's February 2024 eMAR revealed there was no entry for Cerovite with Lutein tablet. Observation of medication on hand for Resident #6 on 02/28/24 at 2:45pm revealed: -There was a bingo card of Ocuvite (a multi-vitamin) with Lutein tablets dispensed on 02/05/24 for 17 tablets with 17 tablets remaining on the bingo card. -There was a bingo card of Ocuvite with Lutein tablets dispensed on 02/22/24 for 28 tablets with 27 tablets remaining on the bingo card.	D 358	(2) All medication aides will have med Admin observations conducted by the Health + Wellness Director or designee, no later than 4/1/24. Those medication Aides identified without a passing score will retake the NC medication course. 4/1/24 (3) The Health + Wellness Director or designee will conduct a retraining for the resident care coordinator and med Aides regarding the review of FL2 for new admission orders 4/1/24	

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D 358	Continued From page 4 Telephone interview with a representative from the facility's contracted pharmacy on 02/28/24 at 8:40am revealed: -The facility generated their own eMARs for residents, including Resident #6. -The pharmacy did not have access to the facility's eMAR system and dispensed medications based on the physician's orders received from the facility. -Resident #6's FL2 dated 02/01/24, was received by the pharmacy on 02/05/24. -The pharmacy dispensed Ocuvite with Lutein as a generic medication for Cerovite with Lutein for Resident # 6. -Resident #6 was dispensed a bingo card with 17 tablets on 02/05/24 and a cycle fill bingo card for 28 tablets on 02/22/24. Interview with a MA on 02/08/24 at 10:30am revealed: -Resident #6 was a new admission to the facility (less than one month). -The facility's clinical staff, Health and Wellness Director (HWD), Health and Wellness Coordinator (HWC) or Resident Care Coordinator (RCC), routinely entered the medication orders for new admission residents on the residents' eMARs. -She had not seen Resident #6's FL2 and medication orders. -The MAs administered medications according to the medications prompted on the eMAR system computer monitor. -Resident #6 had Ocuvite with Lutein available for administration on the medication cart. -She had not administered Ocuvite with Lutein to Resident #6 on 02/28/24 at 8:04 am because there was no order displayed on the eMAR.	D 358	(1) An audit to be completed daily for three (3) weeks by the Health + Wellness Director or designee of physician orders entered into PCC, after two new AIDES have validated order entry process. 4/1/24 (5) To assist with ongoing compliance, the District Director of Clinical Services, Area Director or designee will review new resident admission orders during their next site visit. Results of those audits will be given to the ED or designee for review in the next community QI meeting 4/15/24	

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D 358	Continued From page 5 Interview with the Health and Wellness Director (HWD) on 02/01/24 at 12:50pm revealed: -All medications on Resident #6's FL2 dated 02/01/24 were entered into the eMAR system by a MA, upon admission on 02/05/24 except Cerovite with Lutein according to review of the computer's data entry documentation. - Cerovite with Lutein (Ocuvite with Lutein is generic) was ordered once daily on the FL2 and should have been entered and scheduled for 8:00am along with the other medications ordered once daily. -There was currently no system in place to routinely audit medications entry into the eMAR system other than the procedure to have a second staff member review orders after entry. -MAs should have checked with the HWD, HWC, or RCC when Resident #6 received Ocuvite with Lutein from the pharmacy when staff noticed there was no eMAR entry for Ocuvite with Lutein. -She did not know Resident #6's had not been receiving Ocuvite with Lutein as ordered. Telephone interview with Resident #6's primary care provider (PCP) on 02/28/24 at 2:55pm revealed: -She had not discontinued Resident #6's Ocuvite with Lutein. -The facility should be administering medications as ordered. Based on observations, interviews, and record review, it was determined Resident #6 was not interviewable. Refer to the interview with the Health and Wellness Director (HWD) on 02/01/24 at 12:50pm. Refer to the interview with the Executive Director	D 358		

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D 358	Continued From page 6 (ED) on 02/28/24 at 2:20pm. Refer to the telephone interview with the primary care provider (PCP) on 02/28/24 at 2:55pm. b. Review of Resident #7's current FL2 dated 03/08/23 revealed diagnoses included Alzheimer's disease, and pure hypercholesterolemia. Review of Resident #7's physician's order dated 05/19/23 revealed there was an order to discontinue rosuvastatin 20mg (used to treat elevated cholesterol); start rosuvastatin 40mg once a day. Observation of the morning medication pass on 02/28/24 at 7:55am revealed: -The MA removed medications from the medication cart, compared each medication label to the medications displayed on the eMAR, and administered 9 medications. -The MA administered one rosuvastatin 20mg tablet from a bingo card dispensed on 02/22/24 for 28 tablets. Review of Resident #3's February 2024 eMAR revealed: -There was an entry for rosuvastatin 40mg take on tablet one time a day for high cholesterol scheduled for 8:00am. -There was documentation rosuvastatin 40mg was administered at 8:00am daily from 02/01/24 to 02/28/24. -There was no entry for rosuvastatin 20mg on the eMAR and no documentation of administration for rosuvastatin 20mg. Observation of medication on hand for administration for Resident #7 on 02/28/24 at	D 358		

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D 358	Continued From page 7 9:50am revealed: -There was a bingo card of rosuvastatin 20mg dispensed on 02/22/24 for 28 tablets with 21 tablets remaining. -There were no rosuvastatin 40mg tablets available for administration to Resident #7. Telephone interview with a representative from the facility's contracted pharmacy on 02/28/24 at 8:40am revealed: -The pharmacy did not generate the facility's eMARs and did not have computer access to the information displayed on the facility's eMAR. -The pharmacy created a drug profile for each resident based on current orders for medications sent from the pharmacy to the facility. -The pharmacy received an original order for rosuvastatin 20mg on 04/11/23. -The pharmacy received the order dated 05/19/23 to discontinue rosuvastatin 20mg and start rosuvastatin 40mg once a day. -There was a note in the pharmacy computer that a fax was sent to the facility requesting an electronic medication order for rosuvastatin 40mg with no further information. -The there was no facility response documented; it looked like the pharmacy restarted rosuvastatin 20mg daily so the resident would not be out of the medication. -The pharmacy did monthly cycle fills for Resident #7's rosuvastatin with the fill dates adjusted to allow time to dispense on the cycle fill date (usually around day 22 each month). -The pharmacy received no new medication order for rosuvastatin 40mg, but reactivation of rosuvastatin 20mg one tablet daily with dispensing dates and quantities as follows: -On 11/23/23, a quantity of 28 was dispensed. -On 12/21/23, a quantity of 28 was dispensed. -On 01/18/24, a quantity of 28 was dispensed.	D 358		

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D 358	Continued From page 8 -On 02/15/24, a quantity of 28 was dispensed. -There was no record for dispensing rosuvastatin 40mg to Resident #7. Interview with the morning MA on 02/28/24 at 10:17am revealed: -She routinely pulled residents' medications from the medication cart and compared the name of the medication to the displayed name on the eMAR. -She was supposed to thoroughly compare the name, strength and directions. -She overlooked Resident #7's rosuvastatin was 40mg on the eMAR and for 20mg of rosuvastatin on the bingo card. -The facility's clinical staff, Health and Wellness Director (HWD), Health and Wellness Coordinator (HWC) or Resident Care Coordinator (RCC), routinely entered the medications orders for new admission residents. -The MAs could enter orders if a second staff member reviewed the orders and the orders matched. -There was a new order tracking book staff were supposed use to help track entry of orders and follow through with delivery of the medication from the pharmacy. -She did not know why the rosuvastatin had gone so long without staff realizing the strength was incorrect. -She had never administered 2 of the 20mg rosuvastatin to equal 40mg when she administered the medication to Resident #7. Interview with the Health and Wellness Director (HWD) on 02/01/24 at 12:50pm revealed: -The pharmacy had always accepted the physicians' orders written by the primary care provider (PCP) on facility's order sheet in the past.	D 358		

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D 358	Continued From page 9 -She did not know why the pharmacy had refused to send the rosuvastatin 40mg when ordered on 05/19/23. -The facility's eMAR system showed the new order entered as rosuvastatin 40mg once daily in May 2023. -The MAs should have questioned the eMAR documenting 40mg daily and the pharmacy sending 20mg daily and either have contacted the PCP or the HWD, HWC or RCC for checking on the order. -There was currently no system in place to routinely audit medications entry into the eMAR system other than the procedure to have a second staff member review orders after entry. -She did not know Resident #7 was receiving rosuvastatin 20mg daily instead of 40mg daily. Based on observations, interviews, and record review, it was determined Resident #7 was not interviewable. Refer to the interview with the Health and Wellness Director (HWD) on 02/01/24 at 12:50pm. Refer to the interview with the Executive Director (ED) on 02/28/24 at 2:20pm. Refer to the telephone interview with the primary care provider (PCP) on 02/28/24 at 2:55pm. 2. Review of Resident #5's current FL-2 dated 10/17/23 revealed: -Diagnoses included vascular dementia, unspecified convulsions, cerebral infarction and history of transient ischemic attack. -The resident had constant disorientation. -There was an order for diazepam rectal gel 10mg rectally every 24 hours as needed for	D 358		

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D 358	Continued From page 10 seizures. Review of Resident #5's signed physician's orders dated 01/10/24 included an order for diazepam rectal gel 10 mg rectally every 24 hours as needed for seizures. Observation of medications on hand for administration on 02/28/24 at 3:30pm revealed Resident #5 did not have any diazepam available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 02/28/24 at 12:00pm revealed: -Resident #5 did have a order for diazepam rectal gel 10 mg rectally every 24 hours as needed for seizures dated 10/17/23. -Diazepam was a schedule IV-controlled substance and the pharmacy required a hard copy of the prescription from the physician. -The diazepam for Resident #5 was never dispensed to the facility. -The pharmacy sent a request for a prescription to the facility on 10/30/23 via fax and did not receive a response. -Typically, the request was sent to the facility and the provider. -There was no evidence the request for a prescription was sent to the provider. Interview with a medication aide (MA) on 02/28/24 at 3:35pm revealed: -There was an order for Resident #5 to have diazepam gel rectally every 24 hours as needed for seizures. -There was no diazepam available to administer for Resident #5. -She did not know why the diazepam was not available for Resident #5. -Resident #5 had not had any seizures that she	D 358		

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D 358	Continued From page 11 was aware of. Interview with the Health and Wellness Director (HWD) on 02/01/24 at 12:50pm revealed: -All faxes were received in one location in the facility and MA's and clinical staff had access. -They were to remove the faxes and enter orders in eMar system and send them to the pharmacy. -She thought maybe the facility never received the request for the prescription for the diazepam. -Currently there was not a system in place to check that residents had the medications on hand according to the eMar and the physician's orders. Telephone interview with the primary care provider (PCP) on 02/28/24 at 2:55pm revealed: -Resident #5 was prescribed diazepam for seizures. -She was not aware Resident #5 did not have diazepam available for administration. -Resident #5 did not have any seizure activity and was on another medication also for seizures. -The facility should be administering medications as ordered. Based on observations, interviews, and record review, it was determined Resident #5 was not interviewable. Refer to the interview with the Health and Wellness Director (HWD) on 02/01/24 at 12:50pm. Refer to the interview with the Executive Director (ED) on 02/28/24 at 2:20pm. Refer to the telephone interview with the primary care provider (PCP) on 02/28/24 at 2:55pm. _____	D 358		

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D 358	Continued From page 12 Interview with the Health and Wellness Director (HWD) on 02/01/24 at 12:50pm revealed: -She was responsible for ensuring medications were administered as ordered at the facility. -There had been staff turnover in the HWC and RCC positions but both positions had been recently filled. -The HWD, HWC, RCC and medication aides could enter orders into the facility's eMAR system. -The staff entering the orders should send the medication orders to the contracted pharmacy when the orders were entered into the eMAR system. -All orders were supposed to be entered into the eMAR system and reviewed by a second staff member for completeness and accuracy. -The facility generated eMARs for the residents. Interview with the Executive Director (ED) on 02/28/24 at 2:20pm revealed: -The facility's clinical staff, HWD, HWC, RCC, and MAs were responsible to ensure medications were administered as ordered. -The facility staff members entered orders into the eMAR system, faxed all medication orders to the contracted pharmacy provider, and should be monitoring medication administration for accuracy and completion. -He did not know any resident was not receiving medications as ordered. Telephone interview with the primary care provider (PCP) on 02/28/24 at 2:55pm revealed: -She had discovered medications that were ordered but not being administered because the order did not appear on the eMAR in the past, and discussed the issue with the HWD at the time. -The current HWD had recently requested that all	D 358		

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D 358	Continued From page 13 her resident encounter notes and medications orders be emailed to the HWD and the ED to ensure all orders were processed correctly. -She expected the facility to check the fax machines, all progress notes and copies of electronic medication orders sent to the facility from the pharmacy to ensure residentss' orders were current and accurate. -The facility should be administering medications as ordered.	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 observations, interviews and record	D 367	(1) The new Aide will complete re-training with the Health & Wellness Director and pass the NC new course no later than 3/27/24. Unable to retroactively correct for Lorazepam 0.5mg (resident #1), and morphine sulfate 100mg/5ml oral solution take 0.25ml po Q 4 hours prn for pain and Vitamin D3 2000 IU for resident #7. PCP and hospice notified on 2/28/24 by HWD. Legal rep notified on 2/28/24 by HWD. 3/27/24	

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D 367	Continued From page 14 reviews, the facility failed to ensure the accuracy of the electronic medication administration record (eMAR) for 1 of 4 residents observed during medication administration related to a medication to a vitamin supplement (#7); and for 2 of 5 sampled residents including documentation of administration of an as needed medications used to treat anxiety (#1) and a medication used to treat seizures (#5). The findings are: 1. Review of Resident #7's current FL2 dated 03/08/23 revealed diagnoses included Alzheimer's Disease, and Pure hypercholesterolemia. Review of Resident #7's physician's order dated 11/28/23 revealed an electronic order for Vitamin D3 2000 international units (iu) once a day. Observation of administration of the morning medications on 02/28/24 at 7:55am revealed: -The medication aide (MA) removed medications from the medication cart, compared each medication label to the medications displayed on the electronic medication administration record (eMAR), and administered 9 medications to Resident #7. -The MA administered one Vitamin D3 (a vitamin D supplement) 2000 iu tablet from a bingo card labeled as dispensed on 02/22/24 for 28 tablets. Review of Resident #7's February 2024 eMAR revealed: -There was no entry for Vitamin D 2,000 units daily scheduled at 8:00am. -There was no documentation Vitamin D3 2000 iu was administered on 02/28/24.	D 367	(2) MAR Aides will have MAR Admin observations completed by the HUD or designee no later than 4/1/24. Those MAR Aides identified without a passing score will retake the NC MAR course. 4/1/24 (3) Retraining completed by the HUD or designee for the RCC and MAR Aides on the New Order Tracking process, MAR availability, and documentation of effectiveness for Schedule 2 Narcotics. 4/1/24 (4) To assist with ongoing compliance, the HUD or designee will audit narcotic logs for MAR availability and documentation weekly for 2 months. 6/1/24	

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D 367	Continued From page 15 Review of Resident #7's January 2024 eMAR revealed: -There was no entry for Vitamin D 2,000 units daily. -There was no documentation Vitamin D3 2000 iu was administered from 01/01/24 to 01/31/24. Observation of medication on hand for Resident #7 on 02/28/24 at 10:28am revealed: -There was a bingo card of Vitamin D 2000 iu tablets dispensed on 02/22/24 for 28 tablets with 21 tablets remaining. -There were 7 opportunities for administration of Vitamin D3 2000 iu from 02/22/24 to 02/28/24 and 7 tablets of Vitamin D3 2000 iu tablets punched from the bubble card. Telephone interview with a representative from the facility's contracted pharmacy on 02/28/24 at 9:10am revealed: -The pharmacy does not generate the facility's eMARs and does not have computer access to the information displayed on the facility's eMAR. -The pharmacy creates a drug profile for each resident based on current orders for medications sent to the pharmacy by the facility or the providers. -The pharmacy received an order for Vitamin D3 2000 iu on 11/28/23. -The pharmacy supplied the facility with Vitamin D3 2000 iu, for Resident #7, one tablet daily as follows: -On 11/28/23, a quantity of 2 was dispensed. -On 11/29/23, a quantity of 28 was dispensed. -On 12/21/23, a quantity of 28 was dispensed. -On 01/18/24, a quantity of 28 was dispensed. -On 02/15/24, a quantity of 28 was dispensed. Interview with a MA on 02/28/24 at 10:15am revealed:	D 367		

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D 367	Continued From page 16 -She routinely pulled a resident's medication from the medication cart drawer, compared the medications to the eMAR and removed the medications from the bubble cards. -She administered Vitamin D3 2000 iu because it was on the cart, grouped with the medications scheduled at 8:00am and labeled for administration once daily. -Resident #7 had an order listed on the eMAR for a calcium plus Vitamin D3 supplement. -She thought the resident's calcium supplement and Vitamin D3 were in separate tablets instead of an 2 different orders for medications containing Vitamin D3. -The facility's clinical staff, Health and Wellness Director (HWD), Health and Wellness Coordinator (HWC) or Resident Care Coordinator (RCC), routinely entered the medications orders for new admission residents. -The Vitamin D3 2000 iu order should have been added by either the MA on duty at the time the order was received, or by the facility's clinical staff. -There was no staff routinely auditing medications on the medication cart compared to the eMAR for accuracy and completeness. -The pharmacy staff did cart audits when they did a pharmacy review. Interview with the Health and Wellness Director (HWD) on 02/28/24 at 12:50pm revealed: -The facility staff, not the contracted pharmacy, entered all medication orders into the facility's eMAR system. -The facility had a medication order tracking book that was supposed to be used to ensure all new medication orders were entered into the eMAR system and faxed to the contracted pharmacy. -Sometimes the primary care provider (PCP) left new orders at the facility and sometimes she	D 367		

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D 367	Continued From page 17 electronically sent the orders directly to the contracted pharmacy. -The contracted pharmacy sent the facility a copy of all medication orders received electronically. -Resident #7's physician order dated 11/28/23 for Vitamin D3 2000 iu was sent to the facility by the pharmacy. -The Vitamin D3 order was not entered into the new order tracking book for some unknown reason. -The contracted pharmacy sent the Vitamin D3 2000 iu to the facility and at appeared staff administered the medication daily. -She reviewed a printout of scheduled medications that had were missing documentation (holes) of administration randomly. -She did not have a system in place to routinely audit eMAR documentation compared to the residents' medication orders. Telephone interview with Resident #7's PCP on 02/28/24 at 1:45pm revealed: -The facility should be accurately documenting medication administration. -The NP used the eMAR information including, frequency of administering prn medications and the effectiveness as documented, the monitor residents' medication regimen and outcome. -If the medication administrations are not correctly documented, the provider would not be able to determine if changes to medication therapy is needed to meet therapeutic goals. Interview with the Executive Director (ED) on 02/28/24 at 2:20pm revealed the clinical staff, composed of the HWD, Health and Wellness Coordinator (HWC), Resident Care Coordinator (RCC), and MAs, would be responsible to ensure that the eMARs were accurate to include	D 367		

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D 367	Continued From page 18 medications ordered and administration of medications. 2. Review of Resident #1's current FL2 dated 01/05/24 revealed diagnoses included unspecified neurocognitive disorder, and agitation due to dementia. Review of Resident #1's physician's orders dated 02/07/24 revealed lorazepam (a controlled substance used to treat agitation/anxiety) 0.5mg one tablet every 8 hours as needed for anxiety. Observation of medication on hand for administration for Resident #1 on 02/27/24 at 3:27pm revealed the resident had a bingo card of lorazepam 0.5mg labeled one tablet every 8 hours as needed for anxiety dispensed on 02/07/24 for a quantity of 30 tablets, with 9 tablets remaining. Review of the facility's "individual narcotic log" sheet generated on 02/07/24 for Resident #1's lorazepam 0.5mg tablets dispensed from the contracted pharmacy on 02/07/24 for a quantity of 30 tablets revealed: -There was an entry for lorazepam 0.5mg take one tablet every 8 hours as needed for anxiety. -There was a beginning inventory entry for 30 tablets received on 02/07/24. -There were 21 lorazepam 0.5mg tablets signed out as administered from 02/07/24 to 02/27/24. Review of Resident #1's lorazepam 0.5mg on hand for administration compared to the corresponding facility's "individual narcotic log" sheet generated on 02/07/24 for 30 tablets received revealed the quantity on hand (9) matched the quantity (9) remaining on the log.	D 367		

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D 367	Continued From page 19 Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 0.5mg take one (1) tablet every 8 hours as needed for anxiety. -Lorazepam 0.5mg was documented as administered, and effective, on 9 days from 02/07/24 to 02/27/24 (at 8:00am on 02/09, 02/10, 02/11, 02/12, 02/16, 02/19, 02/22, 02/24 and 02/26/24). Review of Resident #1's facility's "individual narcotic log" sheet for 30 lorazepam 0.5mg tablets dispensed on 02/07/24 compared the Resident #1's February 2024 eMAR revealed there were 12 lorazepam 0.5mg signed out as administered on the narcotic log but not documented as administered or effectiveness documented on the February 2024 eMAR with examples as follows: -On 02/08 (no time indicated), one tablet was signed out on the narcotic log but not documented as administered or effectiveness on the eMAR. -On 02/13 at 8:00am, one tablet was signed out on the narcotic log but not documented as administered or effectiveness on the eMAR. -On 02/14 at 8:00am, one tablet was signed out on the narcotic log but not documented as administered or effectiveness on the eMAR. -On 02/20 at 8:00am and at 8:00pm, one tablet was signed out on the narcotic log but not documented as administered or effectiveness on the eMAR for each time. -On 02/27 at 8:00am, one tablet was signed out on the narcotic log but not documented as administered or effectiveness on the eMAR. Interview with a day shift medication aide (MA) on	D 367		

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D 367	Continued From page 20 02/27/24 at 3:23pm revealed: -The facility staff were supposed to document administration of as needed (prn) medications on the residents' eMARs at the time the medications were administered. -The MAs were supposed to evaluate the resident for effectiveness of the medication at one hour after the administration and document the effectiveness in the eMAR. -Medications administered prn required the MA to access the medication on the resident's eMAR, document administration on the eMAR at the time of administration, and complete documentation when the eMAR prompted an effectiveness response one hour after administration. -The procedure for controlled medications administered prn was for the MA to bring the prn medication up on the eMAR screen, prepare the prn medication by retrieving the medication from the locked drawer on the medication cart, sign the medication out on the facility's "individual narcotic log" for the resident's medication, administer the medication, and document administration on the eMAR. -The MAs always signed out a controlled medication on the facility's "individual narcotic log" at the time they prepared the controlled medication because they had to do a shift change count of controlled medications before they could leave and the count had to match. -If a MA was busy helping residents or there were a lot of distractions, the MA might administer a prn medication with the intention of accessing the eMAR a little bit later and forget to enter the prn medication on the eMAR. -If there were tablets she had signed out on the "individual narcotic log" but not documented on the corresponding resident's eMAR, it would have been an oversight. -She did not know if the facility had audits for	D 367		

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D 367	Continued From page 21 ensuring prn medications were documented on the eMAR for administration and effectiveness. Interview with the Health and Wellness Director 02/27/24 at 4:05pm revealed: -The facility, not the contracted pharmacy, entered medication orders into the facility's eMAR system. -The MAs should be documenting administration of medications on the resident's eMAR for all medications, including prn medications administered. -She reviewed a printout of scheduled medications that had were missing documentation (holes) of administration randomly. -She did not have a system in place to audit eMAR documentation of prn medications, including controlled medications, for accuracy of administration and effectiveness. -MAs were responsible to do controlled medication shift counts and reconciliation prior to exchanging medication cart keys, but that did not include checking the on hand quantity compared to eMAR documentation for prn controlled medications. Interview with a second day shift MA on 02/28/24 at 10:30am revealed: -The MAs had to reconcile the count for controlled medications by comparing the quantity of medication on hand to the quantity remaining on the facility's "individual narcotic log" for each controlled medication prior to turning over the keys to the medication cart to the oncoming MA. -She routinely followed the procedure for administering prn medications, and especially controlled medications, to ensure she signed the medication out on the narcotic log and documented on the resident's eMAR.	D 367		

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D 367	Continued From page 22 Telephone interview with Resident #1's primary care provider (PCP) on 02/28/24 at 1:45pm revealed: -The facility should be accurately documenting medication administration. -The NP used the eMAR information including, frequency of administering prn medications and the effectiveness as documented, the monitor residents' medication regimen and outcome. -If the medication administrations are not correctly documented, the provider would not be able to determine if changes to medication therapy is needed to meet therapeutic goals. Interview with the Executive Director (ED) on 02/28/24 at 2:20pm revealed the clinical staff, composed of the HWD, Health and Wellness Coordinator (HWC), Resident Care Coordinator (RCC), and MAs, would be responsible to ensure that the eMARs were accurate to include medications ordered and administration of medications. 3. Review of Resident #5's current FL-2 dated 03/17/23 revealed: -Diagnoses included Parkinson's disease and dementia. -There was an order for morphine 100mg/5ml give 0.25mg as needed for pain or shortness of breath. Record review revealed there was a prescription summary dated 01/20/24 for morphine concentrate 100mg/5ml oral solution take 0.25ml by mouth every 4 hours as needed for pain or shortness of breath. Review of a hospice collaboration note dated	D 367		

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D 367	Continued From page 23 01/24/24 revealed: -A routine staff nurse visit was conducted. -Resident #3 did not have any signs or symptoms of pain. Review of Resident #5's December 2023 electronic medication administration record (eMAR) revealed there was no entry for morphine concentrate 100mg/5ml oral solution take 0.25ml by mouth every 4 hours as needed for pain or shortness of breath. Review of Resident #5's January 2024 eMAR revealed there was no entry for morphine concentrate 100mg/5ml oral solution take 0.25ml by mouth every 4 hours as needed for pain or shortness of breath. Review of Resident #5's February 2024 eMAR revealed there was no entry for morphine concentrate 100mg/5ml oral solution take 0.25ml by mouth every 4 hours as needed for pain or shortness of breath. Observation of Resident #5's medications on hand for administration on 02/27/24 at 3:00pm revealed there were morphine prefilled syringes available for administration with a dispensed date of 01/24/24. Interview with a Medication Aide (MA) on 02/27/24 at 3:05pm revealed: -Resident #5 had morphine syringes available for administration. -She never administered morphine to Resident #3. -She did not think Resident #3 had pain. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 02/27/24 at	D 367		

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D 367	Continued From page 24 8:55am revealed: -The pharmacy received Resident #5's FL-2 dated 03/17/23 that included the order for morphine concentrate 100mg/5ml oral solution take 0.25ml by mouth every 4 hours as needed for pain or shortness of breath. -The pharmacy sent a 5 day supply of morphine concentrate to the facility on 01/20/24. -The pharmacy did not add orders to the eMAR. Telephone interview with a staff nurse from the facility's contracted Hospice provider on 02/28/24 at 1:15pm revealed: -Resident 53 was admitted to hospice on 01/07/21. -When a resident begins hospice, an order for morphine concentrate 100mg/5ml oral solution take 0.25ml by mouth every 4 hours as needed for pain or shortness of breath is initiated so it is on hand if the resident needs it. -She saw Resident #5 on 02/26/24 and she did not seem to be uncomfortable. -She thought the physician sent the prescription for the morphine right to the pharmacy and the pharmacy would add the order to the eMAR. -She did not check the eMAR when she last visited Resident #3 on 02/26/24. Interview with the Health and Wellness Director (HWD) on 02/28/24 at 1:45pm revealed: -Hospice sent orders right to the pharmacy. -A copy of the order should also be sent to the facility but sometimes they didn't get a copy. -She and the MA's could enter orders onto the eMAR. -She did not understand how Resident #5's order for morphine did not get added to the eMAR. Interview with the Executive Director (ED) on 02/28/24 at 2:20pm revealed:	D 367		

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BROOKDALE CHAPEL HILL	2230 FARMINGTON DRIVE CHAPEL HILL, NC 27514

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D 367	Continued From page 25 -The facility staff members entered orders into the eMAR system, faxed all medication orders to the contracted pharmacy provider, and should be monitoring medication administration for accuracy and completion. Telephone interview with the primary care provider (PCP) on 02/28/24 at 2:55pm revealed: -She had discovered medications that were ordered but not being administered because the order did not appear on the eMAR in the past and discussed the issue with the HWD at the time. -The current HWD had recently requested that all her resident encounter notes and medications orders be emailed to the HWD and the ED to ensure all orders were processed correctly.	D 367		