

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/05/2015
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NAME OF PROVIDER OR SUPPLIER BROOKDALE DICKINSON AVENUE	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DICKINSON AVENUE GREENVILLE, NC 27834
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D 000	Initial Comments The Adult Care Licensure Section and the Pitt County Department of Social Services conducted an annual and follow-up survey on November 3, 2015 - November 5, 2015.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the administration of medications, including insulin, acetaminophen, effexor, metformin, and flomax, by staff were in accordance with prescribing practitioner's orders and manufacturer's directions for 3 of 11 residents (Residents #4, #7, #8) observed during the medication pass. The findings are: The medication error rate was 13% as evidenced by the observation of 5 errors out of 36 opportunities during the 5:00pm medication pass on 11/3/2015, and the noon medication pass on 11/4/2015. 1. Review of Resident #4's current FL-2 dated 05/13/2015 revealed: - Resident #4's admission date was 02/03/2014.	D 358		

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

Mel Barker

TITLE

Executive Director

(X6) DATE

11/30/15

*Reviewed & accepted
11/30/15 HF*

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D 358	<p>Continued From page 1</p> <ul style="list-style-type: none"> - Resident #4's diagnoses included Diabetes Mellitus and Dementia. - Resident #4's medications orders included Novolog Flexpen 8 units 3 times a day with meals, Lantus Solstar 10 units at hour of sleep daily, finger stick blood sugar (FSBS) before meals and at bedtime, if FSBS is less than 70mg/dl give any of the following: 4oz of juice, 7oz of skim milk, 4oz of regular soda or 3 glucose tabs. Recheck FSBS 15 minutes after glucose source, if blood sugar is not 100mg/dl or greater repeat the above glucose source. If not mealtime, give a snack. - An order dated 06/25/2015 increased Novolog Flexpen insulin to 10 units 3 times a day with meals. - Orders included to call a local home health agency if the Resident is sweaty, pale or experiencing nausea or vomiting as well if FSBS is less than 60mg/dl or greater than 500mg/dl. Meals were observed being served in the Special Care Unit at 8am, 12pm and 5pm. Observation of Medication Aide (MA) on 11/03/2015 during 3pm-11pm shift revealed: <ul style="list-style-type: none"> - The MA performed a FSBS and the Resident's FSBS reading was 273 mg/dl. - The MA turned the dose selector of the Novolog Flex pen to 10 units and administered the Novolog without performing an "airshot" (a specific way of ensuring that air is removed from the insulin pen and ensuring proper dose is administered). - After injecting insulin, the MA immediately withdrew the needle from the skin. Interview with the MA on 11/03/2015 at 4:35 pm revealed: <ul style="list-style-type: none"> - The MA had never heard of an "air shot". - The MA was not aware that after insulin was injected using the Novolog Flexpen, the needle 	D 358		

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D 358	<p>Continued From page 2</p> <p>was to remain in situ with button pressed for 6 seconds.</p> <p>Interview with the facility's Health and Wellness Director on 11/03/2015 at 4:45pm revealed:</p> <ul style="list-style-type: none"> - The Health and Wellness Director was not aware that "air shots" were not being performed by all the MAs. - The Health and Wellness Director would initiate training immediately on the proper usage. - She would monitor for significant changes in the Resident's FSBS once correct injection techniques are uniformly used. <p>Surveyor returned to observe Resident #4's lunch time insulin being administered on 11/04/2015 at 10:55 am.</p> <p>Interview with the MA on 11/04/2015 at 10:58 am revealed:</p> <ul style="list-style-type: none"> - The MA had "just" administered Resident #4's lunch insulin. - Lunch was served "around 11:45 am to 12 pm." - Resident #4's FSBS was 251mg/dl. - Insulin can be given 1 hour before a meal. <p>Telephone interview with the facility pharmacy provider 11:15 am on 11/05/2015 revealed:</p> <ul style="list-style-type: none"> - If an "air shot" is not performed before using an insulin pen, the Resident could be getting less insulin than ordered. - If an insulin pen is not held in place for the recommended time after an injection, the Resident could be getting less insulin than ordered. - If Novolog insulin is administered 1 hour or more before a meal, the Resident's blood sugar could drop too low. - The recommendation is to administer Novolog insulin "no more than 30 minutes before a 	D 358		

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D 358	<p>Continued From page 3</p> <p>meal-15 minutes would be better." - "The newer insulin act much faster than previous versions."</p> <p>Interview with Health and Wellness Coordinator on 11/05/2015 at 2:30 pm revealed: - The MA re-training on insulin pens has already started. - Appropriated administration times of insulin, as well as all other medications and proper documentation of times given will be reviewed during in-services. -The Health and Wellness Coordinator plans to continue in-services for MAs as well as all Resident care staff.</p> <p>Based on interview, observation and record review, the Resident was determined to not be interviewable.</p> <p>2. Review of Resident #8's current FL-2 dated 03/12/2015 revealed: - Resident #8's diagnoses included fractured subtrochanteric, Osteoporosis, Hyperlipidemia, Alzheimer's disease, constipation, depression, and anxiety. - Ordered medications included Tylenol 500 mg by mouth four times per day. - Review of Resident #8 Medication Administration Record for the month of November revealed Tylenol ordered 6am-12pm-6pm-12am.</p> <p>Observation of the MA during 3pm-11pm medication pass on 11/03/2015 revealed: - The MA crushed 2 tablets Tylenol 325mg and administered by mouth to Resident #8 at 3:50pm.</p> <p>Telephone interview with the facility pharmacy provider at 11:15 am on 11/05/2015 revealed:</p>	D 358		

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D 358	<p>Continued From page 4</p> <p>- Tylenol can be given safely every 4 hours but documentation should reflect actual time the medication is given.</p> <p>3. Record review of the current FL-2 dated 07/10/2015 for Resident #7 revealed diagnoses included open recurrent hernia repair, urinary retention, diabetes mellitus, hypertension, cerebrovascular accident, atrial fibrillation, neurogenic bladder, seizure secondary to cerebrovascular accident, peripheral vascular disease, depression, and gastroesophageal reflux disease.</p> <p>Review of the current FL-2 revealed medication orders included:</p> <ul style="list-style-type: none"> - Venlafaxine (generic for Effexor used to treat depression) 75mg two times a day with meals. - Metformin (generic for Glucophage used to treat diabetes mellitus) 500mg two times a day with meals. - Tamsulosin (generic for Flomax used to treat urinary disorders) 0.4mg capsule daily. <p>Record review of physician orders revealed:</p> <ul style="list-style-type: none"> -Subsequent physician orders dated 10/21/2015 revealed no changes with orders for Venlafazine, Metformin and Tamsulosin. -No further physician orders related to Venlafazine, Metformin and Tamsulosin. <p>Observation of the medication pass on 11/03/2015 at 4:15pm revealed:</p> <ul style="list-style-type: none"> -The Medication Aide (MA) prepared and administered 4 medications to Resident #7, in the resident 's room, which included Venlafaxine HCL 75mg tablet, Metformin HCL 500mg tablet, and Flomax 0.4mg capsule. -No food was offered to Resident #7. <p>Interview with Resident #7 on 11/03/2015 at</p>	D 358			

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D 358	<p>Continued From page 5</p> <p>4:15pm revealed: -Resident #7 did not usually take his medication with food. -Resident #7 was not opposed to the idea of taking his medication with food. -Nobody gave Resident #7 food with his pills.</p> <p>Review of the November 2015 MAR with the MA at 4:15pm revealed instructions for Venlafaxine and Metformin to be administered with a meal. Review of the November 2015 Medication Administration Records (MARs) for Resident #7 revealed: -Entry for Venlafaxine HCL 75mg tablet take one tablet twice daily with meals and scheduled for administration at 8am and 5pm daily. -Entry for Metformin 500mg tablet take one tablet two times a day with meals and scheduled for administration at 8 am and 5pm daily.. -Entry for Tamsulosin HCL 0.4mg capsule take one capsule daily and scheduled for administration at 6pm daily.</p> <p>Interview with the MA on 11/03/2015 at 4:17pm revealed: -Resident #7's medications were not administered with food. -Resident #7 would eat supper at 5:00pm. -If a resident's medication were supposed to be administered with a meal, the medications were usually given "a cracker or something". -Resident #7's Venlafaxine and Metformin were supposed to be administered with food. -Resident medications can be administered in the dining room. -Resident #7 was usually in the dining room when the MA administered Resident #7 's medication.</p> <p>Observation on 11/03/2015 from 4:20pm to 4:28pm revealed:</p>	D 358		

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D 358	<p>Continued From page 6</p> <ul style="list-style-type: none"> -The MA went to the kitchen and came out with three packs of peanut butter crackers. -The MA went back to Resident #7's room and offered Resident #7 a pack of the peanut butter crackers. -Resident #7 opened the crackers and began to eat them at 4:28pm. <p>Interview with the MA on 11/03/2015 at 4:35pm revealed:</p> <ul style="list-style-type: none"> -Today was the first time the MA had been "followed" while doing a medication pass. -The MA usually knew what he was doing but "sometimes when somebody follows you, it's different". <p>Interview with the Health and Wellness Director/Registered Nurse (HWD/RN) on 11/04/2015 at 10:15am revealed:</p> <ul style="list-style-type: none"> -The expectation for MA's administering medications ordered to be administered with a meal would be for the medication to be administered when the resident is sitting down with a meal. -MA's were trained to administer medications ordered with a meal when the resident was sitting down with a meal. -If the MAR indicated with a meal, the expectation was that the medication would be administered with a meal. <p>Interview with the pharmacy provider Pharmacist on 11/05/2015 at 10:20am revealed:</p> <ul style="list-style-type: none"> -It was best to administer Metformin and Venlafaxine with food because it lessens upsetting the stomach. -The efficacy of Metformin and Venlafaxine was not affected when the medication was not taken with food. 	D 358		

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D 358	<p>Continued From page 7</p> <p>Interview with the pharmacy provider Pharmacist on 11/05/2015 at 12:15pm revealed: -Tamsulosin was recommended to be administered within 30 minutes of a meal. -Tamsulosin was recommended to be administered about the same time each day.</p> <p>Interview with Resident #7 on 11/05/2015 at 11:30am revealed: -The resident denied having upset stomach. -The resident denied having any problems with digestion.</p> <p>Interview with the Health and Wellness Director/Registered Nurse (HWD/RN) on 11/04/2015 at 10:15am revealed: -The expectation for MA's administering medications ordered to be administered with a meal would be for the medication to be administered when the resident is sitting down with a meal. -MA's were trained to administer medications ordered with a meal when the resident was sitting down with a meal. -If the MAR indicated with a meal, the expectation was that the medication would be administered with a meal.</p> <p>Interview with Resident #7 on 11/05/2015 at 2:40pm revealed: -Resident #7 was not sure of what type of medications he was administered. -Resident #7 felt "fine" when he took his medications. -Resident #7 had not experienced any dizziness or lightheadedness. -Resident #7 usually only got insulin after dinner.</p> <p>Interview with the Health and Wellness Director/Registered Nurse (HWD/RN) on</p>	D 358		

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D 358	<p>Continued From page 8</p> <p>11/05/2015 at 12:30pm revealed: -The expectation for MA's administering medications ordered to be administered at a specific time would be for the medication to be administered at that time. -MA's could administer medications one hour before or one hour after the scheduled time.</p> <p>Interview with the MA on 11/05/2015 at 3:50pm revealed: -The MA was not used to working in the assisted living section of the facility. -The MA usually worked on the 11-7 shift and was used to administering medications on an empty stomach.</p>	D 358		

The following is the Plan of Correction for Brookdale Dickinson Avenue. This Plan of Correction is in regards to the Statement of Deficiency from November 5th, 2015. This Plan of Correction is not to be construed as an admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

10A NCAC 13F .1004(a)

Medication Administration

The Executive Director/ Health and Wellness Director/Resident Care Coordinator/Designee will perform random weekly Medication Administration Record audits along with Medication Passes to observe for compliance in medication administration. Health and Wellness Director/ MAST Pharmacist will conduct retraining for Medication Technicians to include but not limited to review of the medication administration procedures:

Training will be provided to Medication Technicians on proper preparation of all insulin pens including proper technique for "Air Shots"

Training will be provided to Medication Technicians on proper times of medications administration per state regulations.

Training will be provided to Medication Technicians for medications administration in regards to taking them with food.

Training on the proper preparations of all insulin pens was conducted by the Health and Wellness Director on November 5th, 2015 and further diabetic training was completed by the MAST Pharmacy Consultant on November 17th, 2015.

Training on proper times of medication administration and administering medications with food was conducted on November 5th 2015 by the Health and Wellness Director, and reviewed again on November 19th, 2015 at the Monthly Med Tech Meeting.

Signature of Executive Director/Date Teri Barker, ED 11/30/15
Teri Barker, Executive Director of Brookdale Dickinson Avenue.

Forte, Hope

From: Teri Barker <tbarker@brookdale.com>
Sent: Monday, November 30, 2015 3:30 PM
To: Forte, Hope
Subject: RE: Brookdale Dickinson Avenue 2015-11-23 SODBL/SOD R1OS12-4WP711
Attachments: POC for Brookdale Dickinson Avenue.pdf

Here is our plan of correction. I signed the front page of the survey and added the POC at the end also with my signature. Please let me know if you need anything else from me.

Thank you,

Teri Barker LPN

Executive Director

Closer relationships live here every day.

Brookdale Dickinson Ave (BU 18230)

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www.brookdale.com | www.brookdale.com/Greenville



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From: Forte, Hope [mailto:hope.forte@dhhs.nc.gov]
Sent: Monday, November 23, 2015 4:50 PM
To: Teri Barker
Cc: sharon.alexander@pittcountync.gov; DHHS.DHSR.AdultCare.Star; Rackley, Bridget W; Stancil, Ila; Oakley, Eva
Subject: Brookdale Dickinson Avenue 2015-11-23 SODBL/SOD R1OS12-4WP711

Dear Ms. Barker:

Please find the Statement of Deficiencies and accompanying letter for the annual and follow-up survey on November 3-5, 2015 attached to this e-mail. If the Statement of Deficiencies includes citations or violations for which a plan of correction is required, please read the attached letter carefully for instruction on completing the plan of correction. **PLEASE NOTE: WE WILL NOT ACCEPT A FAXED PLAN OF CORRECTION! We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted.** A response to the plan of correction will be sent ONLY if the plan of correction is not approved. Please retain a copy for your files.

The attached letter also contains information regarding your right to request an Informal Dispute Resolution (IDR) of any cited deficiencies or violations. For more information about the IDR process please visit our website at <http://www.ncdhhs.gov/dhsr/acls/idr.html>.

If you have any questions regarding the information provided in or attached to this email, please call our office at (910) 305-5145. Please be aware that information sent via electronic mail is immediately available for release to the public. Therefore, the information contained in and attached to this e-mail is now public information.

Sincerely,

Hope Forte, RN

Facility Survey Consultant
Adult Care Licensure Section
Division of Health Service Regulation

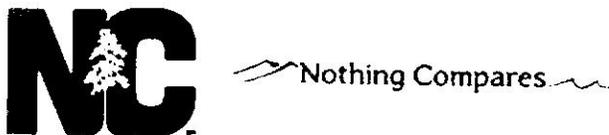
STAR RATING

If the Statement of Deficiencies attached to this email is a result of an annual, follow-up or complaint inspection a star rating certificate and worksheet will be issued within 45 days of the date of this email. If you would like to know more information about the NC Star Rated Certificate Program or view facility ratings, please visit the star rating website at <http://www.ncdhhs.gov/dhsr/acls/star/index.html>. If you have questions about this facility's star rating or the rating program in general, please send an email with your questions to the star rating customer service email address at DHSR.AdultCare.Star@lists.ncmail.net.

Hope Forte, RN
Facility Survey Consultant
Division of Health Service Regulation, Adult Care Licensure Section
North Carolina Department of Health and Human Services

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