Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036012	A. BUILDING: _____ B. WING _____	11/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE UNION	1717 UNION ROAD GASTONIA, NC 28054

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D 000	Initial Comments The Adult Care Licensure Section and the Gaston County Department of Social Services conducted an annual survey and complaint investigation on November 07 and November 08, 2017. The complaint investigation was initiated by the Gaston County Department of Social Services on September 19, 2017.	D 000	See attached POC	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 2 of 6 sampled residents (Resident #1 and Resident #6) with physician orders for a texture modified diet. The findings are: A. Review of Resident #1's current FL2 dated 12/21/16 revealed: -Diagnoses included dysphagia (difficulty swallowing) and aspiration (a condition in which food or liquid is inhaled into a person's airways). -There was no documentation of a diet order. Review of Resident #1's Physician's Diet Order sheet dated 10/30/17 revealed: -A physician's order for a texture modified diet. -There was documentation the texture modified	D 310		

Revised + Accepted 12-22-17
Rachel Kay RN

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D 310	Continued From page 1 diet offered food which was moist and soft-solid with all meats and poultry to be ground with the exception of small tender pieces of meat allowed in soups. Review of the therapeutic diet list posted in the kitchen on 11/07/17 revealed Resident #1 was to be served a texture modified diet. Review of the therapeutic diet menu for lunch on 11/07/17 revealed residents on a texture modified diet were to be served: -4 ounces (oz.) garlic butter cod served with 2 oz. veloute sauce or other gravy, a baked potato peeled with 1 oz. basic poultry gravy or other gravy, buttered mixed vegetables with corn and lima beans omitted, and a dinner roll with butter. -2 oz. mini maple cream pie instead of pecan pie. Observation on 11/07/17 from 12:00 pm to 12:40 pm of the lunch meal service in Dining Hall B revealed: -Residents were being served by a Personal Care Assistant (PCA) from a push cart containing covered entrée plates and covered dessert plates. -Resident #1 was served 4 oz. garlic butter cod without a sauce or gravy, a baked potato with peel intact and without gravy, mixed buttered squash, green beans and carrots, a dinner roll and pecan pie. -Resident #1 ate without difficulty and consumed 100% of the cod, 75% of the mixed buttered squash, green beans and carrots, 50% of the potato but none of the peel and none of the roll. Observation on 11/07/17 at 12:25 pm revealed: -The PCA removed the pecan pie from Resident #1's place setting before she was able to eat it and replaced it with yogurt.	D 310		

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D 310	Continued From page 2 -Resident #1 left the dining room with yogurt in hand. Interviews on 11/07/17 at 12:24 pm and 1:10 pm with the PCA serving food in Dining Hall B revealed: -She used a typed list containing the residents' names and diet orders to know which meal belonged to which resident. -The kitchen staff had the same list and would plate residents' meals according to this list and send to Dining Hall B to be served by the PCAs. -She was unaware that residents on a texture modified diet should not receive pecan pie. -She had served desserts with nuts to residents on a texture modified diet on previous days. -She had never witnessed any of the residents choking on the nuts. -The kitchen staff had given her only pecan pie to serve to all residents in Dining Hall B. Interview on 11/07/17 at 2:31 pm with Resident #1 revealed: -She "always received the same food as everyone else" with no modifications in the texture and no additional gravies or sauces added. -She was aware that her physician had ordered a texture modified diet due to swallowing difficulties in the past. -She was unaware that she should not eat pecan pie on a texture modified diet. -The facility had served her desserts with nuts before. -She had no episodes of choking at the facility. Interview on 11/08/17 at 8:22 am with the Dining Services Manager revealed: -Resident #1 being served pecan pie on 11/07/17 was an "oversight" by the PCA.	D 310		

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D 310	Continued From page 3 -Each PCA should know what the residents being served in Dining Hall B could eat based on the typed list of residents' names and diet orders. -He had discussed with all PCAs in that morning's "stand up meeting" that residents on a texture modified diet should be served ice cream instead of pecan pie. -Dietary staff had scooped sugar free ice cream into individual bowls to be served to the residents on the texture modified diet and the carbohydrate controlled diet. -He had been unable to prepare the mini maple cream pie in place of the pecan pie due to maple syrup being unavailable to order. -He was unaware the therapeutic menu indicated that residents on a texture modified diet were to be served a baked potato without the peel and covered with gravy. -Each of the baked potatoes had been buttered prior to serving. -Managers were assigned to observe meals on every weekday to ensure residents received foods appropriate to their diets. -The Business Office Manager was assigned to observe meals on 11/07/17 but he was unsure if she had done so or whether she had been trained on foods appropriate for therapeutic diets. A second interview on 11/08/17 at 9:05 am with the PCA who served food in Dining Hall B revealed: -She had not been told to serve ice cream instead of pecan pie to residents on a texture modified diet. -Dietary restrictions were never discussed in morning "stand up meetings." Telephone interview on 11/08/17 at 10:53 am with a medical representative from Resident #1's physician's office revealed:	D 310		

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D 310	Continued From page 4 -Resident #1 had a history of dysphagia and aspiration. -Resident #1's physician expected the facility to serve a texture modified diet to Resident #1. -Not serving Resident #1 a texture modified diet could cause her to choke and aspirate again in the future. Refer to interview on 11/08/17 at 8:22 am with the Dining Services Manager. Refer to interview on 11/08/17 at 9:30 am with the Executive Director (ED). B. Review of Resident #6's current FL2 dated 06/07/17 revealed: -Diagnoses included airway obstruction and dementia. -A physician's order for a texture modified diet and honey thickened liquids. Review of Resident #6's Physician's Diet Order sheet dated 10/28/17 revealed: -A physician's order for a texture modified diet. -There was documentation the texture modified diet offered food which was moist and soft-solid with all meats and poultry to be ground with the exception of small tender pieces of meat allowed in soups. Review of the therapeutic diet list posted in the kitchen on 11/07/17 revealed Resident #6 was to be served a texture modified diet. Review of the therapeutic diet menu for lunch on 11/07/17 revealed residents on a texture modified diet were to be served: -4 ounces (oz.) garlic butter cod served with 2 oz. veloute sauce or other gravy, a baked potato peeled with 1 oz. basic poultry gravy or other	D 310		

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D 310	Continued From page 5 gravy, buttered mixed vegetables with corn and lima beans omitted, and a dinner roll with butter. -2 oz. mini maple cream pie instead of pecan pie. Observation on 11/07/17 from 12:00 pm to 1:00 pm of the lunch meal service in the main dining room revealed: -Resident #6 was served 4 oz. garlic butter cod without a sauce or gravy, stewed potatoes, mixed buttered squash, green beans and carrots, ½ slice of toast, yogurt, honey thickened milk and honey thickened water. -Resident #6 ate without difficulty and consumed 100% of the garlic butter cod, 75% of the mixed squash, green beans and carrots, 100% of the stewed potatoes, 100% of the toast, 100% of the yogurt, 100% of the thickened milk and none of the water. Review of the therapeutic diet menu for breakfast on 11/08/17 revealed residents on a texture modified diet were to be served fresh baked quiche, a sausage patty ground with 1 oz. beef gravy or other gravy, and a bran muffin with butter. Observation on 11/08/17 from 8:00 am to 8:40 am of the breakfast meal service in the main dining room revealed: -Resident #6 was served a sausage patty cut into ½ inch cubes without gravy, scrambled eggs, 1 slice of toast, honey thickened milk and honey thickened water. -Resident #6 ate without difficulty and consumed 100% of all food, 100% of the honey thickened milk and none of the water. Interview on 11/08/17 at 8:22 am with the Dining Services Manager revealed: -Sausage is usually cut using a knife for residents	D 310		

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D 310	Continued From page 6 on a texture modified diet. -A food processor was not used that morning for grinding the sausage. -He was unaware the therapeutic menu indicated that residents on a texture modified diet were to be served gravy on the sausage. Interview on 11/08/17 at 8:40 am with the Dietary Cook revealed: -She had prepared the sausage for Resident #6. -She had cut the sausage patty with a knife and had not used a food processor to grind the sausage because that was how she had been trained. -She had never used the food processor to grind sausage. -She was unaware that residents on a texture modified diet should be served gravy on their sausage. -She had never served gravy on sausage. Interview on 11/08/17 at 10:09 am with Resident #6's physician revealed: -He had ordered a texture modified diet for Resident #6 due to a history of difficulty with swallowing. -He expected the facility to follow all physicians' orders. Interview on 11/08/17 at 10:12 am with Resident #6 revealed: -She did not experience any difficulty with eating the sausage that morning. -Her meats are "sometimes" that large. -She did not recall ever choking on her food. Refer to interview on 11/08/17 at 8:22 am with the Dining Services Manager. Refer to interview on 11/08/17 at 9:30 am with the	D 310		

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D 310	Continued From page 7 ED. Interview on 11/08/17 at 8:22 am with the Dining Services Manager revealed: -He had been employed at this facility since mid-September 2017. -He had previously been employed at another facility owned by the same company. -The cod fish served to all residents on 11/07/17 had butter on it but no veloute sauce or gravy. -He felt the fish was moist enough for residents on a texture modified diet. -He was responsible for training the Dietary Cooks at the facility. -He planned to provide more training to the Dietary Cooks on how to prepare meals for residents on a texture modified diet. -He planned to provide more education to PCAs on which foods were appropriate to be served to residents on a texture modified diet. Interview on 11/08/17 at 9:30 am with the ED revealed: -She had been employed with this facility for about 4 weeks. -The Dietary Services Manager was responsible for ensuring residents received foods appropriate to their diets. -She was responsible for providing oversight to the Dietary Services Manager. -Managers did "walk throughs" of the dining areas each day to ensure residents were happy with their meals and would refill drinks if needed, but they were not there to ensure residents received foods appropriate to their diets. -She was unsure what training the PCAs had received on foods appropriate to be served to residents on a texture modified diet. -She planned to discuss food service issues with the management staff at future quality assurance	D 310		

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D 310	Continued From page 8 meetings.	D 310		
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, record reviews and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (Resident #1 and #5) who were prescribed digoxin (used to help make the heart beat stronger and with a more regular rhythm), artificial tears (used to treat dry eyes and act as a lubricant), and bacitracin ophthalmic ointment (an antibiotic used to treat bacterial eye infections). The findings are: A. Review of Resident #1's current FL2 dated 12/21/16 revealed diagnoses included atrial fibrillation, dysphagia, aspiration, hypertension, anxiety, hypothyroidism, hypokalemia, dyslipemia, osteroarthritis, depression, and pulmonary embolism.	D 358		

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D 358	Continued From page 9 Review of Resident #1's record revealed an order dated 06/20/17 from Resident #1's licensed prescribing practitioner for digoxin 0.125 mg (used to help make the heart beat stronger and with a more regular rhythm) to be administered one tablet daily at bedtime. Review of Resident #1's September 2017 Medication Administration Record (MAR) revealed: -An entry for digoxin 0.125 mg daily at bedtime. -Digoxin 0.125 mg was documented as administered on 09/01/17 through 09/15/17 and from 09/19/17 through 09/30/17. -Digoxin 0.125 mg was not documented as administered on 09/16/17, 09/17/17 and 09/18/17, documentation of "med not here" for all three dates. Review of Resident #1's October 2017 MAR revealed: -An entry for the administration of digoxin 0.125 mg daily at bedtime. -Digoxin 0.125 mg was documented as administered on 10/01/17 through 10/18/17, 10/20/17, 10/22/17, 10/23/17, and 10/27/17. -Digoxin 0.125 mg was not documented as administered on 10/19/17, no documentation explaining why the digoxin was not given. -Digoxin 0.125 mg was not documented as administered on 10/21/17, "med not on cart" was documented as the the reason medication was not given. -Digoxin 0.125 mg was not documented as administered on 10/24/17, "med not on cart" was documented as the the reason medication was not given. -Digoxin 0.125 mg was not documented as administered on 10/25/17, "med not on cart,	D 358		

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D 358	Continued From page 10 awaiting pharmacy" was documented as the the reason medication was not given. -Digoxin 0.125 mg was not documented as administered on 10/26/17, 10/28/17, 10/29/17, or 10/30/17, no documentation explaining why the digoxin was not given on any of those dates. -Digoxin 0.125 mg was not documented as administered on 10/31/17, with documentation the medication was "on order". Review of Resident #1's November 2017 MAR revealed: -An entry for the administration of digoxin 0.125 mg daily at bedtime. -Digoxin 0.125 mg was documented as administered on 11/06/17 and 11/07/17. -Digoxin 0.125 mg was not documented as administered on 11/01/17,11/02/17, or 11/03/17. no documentation explaining why the digoxin was not administered. -Digoxin 0.125 mg was not documented as administered on 11/04/07 or 11/05/17, documentation "zero on hand , waiting for pharmacy to send" as the reason the dogoxin was not administered as ordered. Observation on 11/08/17 at 2:10 pm on medication on hand for Resident #1 revealed: -There were 28 digoxin 0.125 mg tablets available for administration. -The bottle was filled on 11/06/17 with a quantity of 30 tablets. Interview on 11/07/18 at 10:50 am with a medication aide (MA) revealed: -Resident #1 did not utilize the facility pharmacy, her medications were filled by "an outside pharmacy". -Medications received from an outside pharmacy were filled on an as needed basis.	D 358		

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D 358	Continued From page 11 -The facility had to notify the pharmacy and request a refill when needed. -Each MA was responsible for notifying the pharmacy and requesting refills when needed. -Resident #1's medication refills were called or faxed to the pharmacy 3 to 5 days prior to the medication running out. -It usually took 3 or 4 days for medication to be delivered to the facility from the pharmacy. -She had not notified the pharmacy or reordered the digoxin. -Resident #1's primary care physician was not notified of missed doses of digoxin. Interview on 11/07/17 at 11:00 am with a second MA revealed: -Resident #1 used an outside pharmacy. -The primary care physician was not always notified when a resident was out of medications and medication doses were missed. -Each MA was responsible to notify the licensed prescribing practitioner of missed doses. -She had not notified Resident #1's physician of missed doses of digoxin. -Each MA was responsible for notifying the pharmacy and requesting refills when needed, but she had not notified the pharmacy or reordered the medication herself. Interview on 11/08/17 at 11:20 am with a third MA revealed: -Each MA was responsible for notifying the pharmacy and requesting refills when needed. -There was no documentation completed to reflect which medications had been requested for refills. -She had not notified the pharmacy nor reordered the the digoxin for Resident #1. -The primary care physician was not always notified when a resident is out of medications and	D 358		

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D 358	Continued From page 12 medication doses are missed. -She had not notified Resident #1's physician of missed doses of digoxin. Interview on 11/07/17 at 10:45 am with the Resident Care Director (RCD) revealed: -Each MA was responsible for notifying the pharmacy and requesting refills when needed. -She was unaware Resident #1 had missed doses of digoxin. -She was not informed by the MA's of the digoxin not being available for administration for Resident #1. -MAs should contact the primary care physician when a resident missed any doses of medication. -She was not aware if Resident #1's physician had been notified of missed doses of digoxin. -Each MA was responsible for notifying the pharmacy of needed refills when 3 to 5 doses remained. Interview on 11/07/17 at 10:10 am with Resident #1's pharmacy representative revealed: -The pharmacy delivered medications to the facility on the same day if the refills were requested by 2:00 pm. -The pharmacy delivered medications to the facility the next day if the refills were requested after 2:00 pm. -Medication refills should be called in 3 to 5 days prior to the medication being out. -The facility typically waited until Resident #1 ran completely out of medication or had a one day supply available before calling the pharmacy for a refill. -The pharmacy delivered 30 tablets of digoxin 0.125 mg for Resident #1 on 07/03/07, 08/16/17, 09/19/17, and 11/06/17. -The facility did not request a refill of Resident #1's digoxin in October 2017.	D 358		

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D 358	Continued From page 13 Interview on 11/08/17 at 1:10 pm with the Administrator revealed: -The pharmacy should be called or faxed for a medication refill at least 7 days prior to the medication running out. -Medication cart audits would have to be completed to determine if a resident was out or running out of medication. -She was not aware of Resident #1 missing doses of digoxin. -MAs should notify the primary care physician of any missed doses of medication. Interview on 11/08/17 at 1:35 pm with Resident #1's primary care physician revealed: -"Missed doses of digoxin could cause the heart to get out of rhythm and decrease cardiac output". -"These symptoms could lead to the heart not functioning properly and possibly to a hospitalization". -The physician was not contacted by the facility regarding the missed doses of digoxin for Resident #1. Interview on 11/08/17 at 2:20 pm with Resident #1 revealed: -She had a heart condition and needed to have her prescribed medication every day. -She had not been administered her heart medication (digoxin) "for a few days". -The facility had let her medication run out on several occasions. -She did not report the missed doses of medication to anyone at the facility, because the MA's were aware of it. -She was dependent on the facility to administer her medication as prescribed by her physician. -She was not aware if her physician was notified	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036012	A. BUILDING: _____ B. WING _____	11/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 14 of any missed doses of prescribed medication. B. Review of Resident #5's current FL2 dated 10/10/16 revealed diagnoses included hypertension, recurrent falls, atopic rhinitis. Review of Resident #5's signed physician's orders dated 08/22/17 revealed: -A physician's order for over the counter (OTC) artificial tears to be applied three times per day to both eyes (artificial tears are lubricant eye drops used to treat irritation). -An order for bacitracin ophthalmic ointment, a small amount to be applied to both eyes every day at bedtime. (bacitracin is an antibiotic used to treat bacterial eye infections). Review of Resident #5's August, September, October, and November 2017 Medication Administration Records (MARs) revealed there were no entries for OTC artificial tears or bacitracin ophthalmic ointment. Observation on 11/8/17 at 8:30 am of Resident #5's medications available for administration revealed the OTC artificial tears and bacitracin ophthalmic ointment were not available. Observation on 11/8/17 at 8:40 am of Resident #5's room revealed the resident had 2 containers of OTC artificial tears in her bathroom cabinet and (1) 3.5 ounce (oz.) tube of bacitracin ophthalmic ointment on her dresser. Interview on 11/8/17 at 8:40 am with Resident #5 revealed: -She suffered with dry eyes and used OTC eye drops for her eyes at unspecified times throughout the day. -She had not been administered any eye	D 358		

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D 358	Continued From page 15 medication by staff. -She was aware of how to apply the OTC artificial tears. -A family member provided the OTC artificial tears to Resident #5. Interview on 11/8/17 at 8:35 am with the morning shift medication aide (MA) revealed: -She had been employed with this facility for approximately 3 years. -She had never seen an order for any eye medications for Resident #5. -She had never administered any medications prescribed for the eye to Resident #5. -She was not aware Resident #5 had OTC medication for her eyes in her room. -MAs received all new orders and were responsible for faxing them to the pharmacy, documenting in the resident's record the order was received and faxed, and then filing the medication to the electronic MAR system. -The Resident Care Director (RCD) was responsible for checking behind the MAs to ensure that the process for new orders was complete. -She was not sure how often the RCD had to review new orders. -She did not know why or how the new order was missed. Telephone interview on 11/08/17 at 11:29 am with pharmacy manager at the facility's contracted pharmacy revealed: -The facility was responsible for faxing all new orders to the pharmacy. -All new orders were and were filled within 1 business day. -There were no new orders received for OTC artificial tears or bacitracin ophthalmic ointment for Resident #5.	D 358		

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D 358	Continued From page 16 Interview on 11/08/17 at 10:25 am with the RCD revealed: -She supervised all MAs in the facility. -The MAs were responsible for obtaining new orders, faxing them to the pharmacy, filing the order in the residents record, documenting in the residents record that a new order was received, placing a copy of the new order with fax confirmation into the new order tracking book, and updating the electronic MAR. -She was responsible for checking all new orders were added to the MAR and submitted to the pharmacy and did so daily. -She was not aware that Resident #5 was prescribed any medications to be administered for her eyes. -She thought a MA who no longer worked for the facility placed the order in the record and did not follow the facility's procedure for processing new orders. -She expected all MAs to follow facility procedure once new orders were received. Interview on 11/08/17 at 10:38 am with the facility's Administrator revealed: -She had worked at the facility for about 4 weeks. -Resident care staff were responsible for processing new orders received from the physician. -She was unaware Resident #5 had not received OTC artificial tears and bacitracin ophthalmic ointment as ordered. -She expected the resident care staff to follow physicians' orders for all medications. -She expected the RCD to oversee staff and ensure that orders from physicians were placed on the MAR and followed. Interview on 11/08/17 at 1:03 pm with Resident	D 358		

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D 358	Continued From page 17 #5's Ophthalmologist revealed: -He prescribed OTC artificial tears for dry eyes and bacitracin ophthalmic ointment for blepharitis (inflammation of eyelids). -He expected Resident #5 to have medication applied as ordered. -If the medications were not administered as prescribed it would cause her eyes to be dry and increase the risk of infection to her eyelids. Interview on 11/08/17 at 10:55 am with a nurse for Resident #5's PCP revealed the PCP was not aware that Resident #5 had been prescribed OTC artificial tears and bacitracin ophthalmic ointment. The failure of the facility to administer medications as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (Resident #1 and #5) who were prescribed digoxin (used to help make the heart beat stronger and with a more regular rhythm), artificial tears (used to treat dry eyes and act as a lubricant), and bacitracin ophthalmic ointment (an antibiotic used to treat bacterial eye infections) was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a Plan of Protection on 11/08/17 at 3:30 pm which included: -The facility would complete a medication cart audit on all medication carts on 11/08/17. -The RCD would provide an immediate in-service to all MAs to ensure all medications are available for administration and the understanding that "med unavailable" or "awaiting pharmacy" are not acceptable documentation. -RCD will complete weekly cart audits on all carts to ensure all medications are available for administration.	D 358		

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D 358	Continued From page 18 -The facility will continue with applicable medication in-services to ensure all medications are available for administration. -The facility will follow facility policy concerning a new order tracking form to ensure medications are available for administration. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 23, 2017	D 358		
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 observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to Medication Administration. The findings are: Based on observations, record reviews and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (Resident #1 and #5) who were prescribed digoxin (used to help make the heart beat stronger and with a more regular rhythm), artificial	D912		

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D912	Continued From page 19 tears (used to treat dry eyes and act as a lubricant), and bacitracin ophthalmic ointment (an antibiotic used to treat bacterial eye infections). [Refer to tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		

Plan of Correction

Brookdale Union Assisted Living

The following is the Plan of Correction for Brookdale Union Assisted Living regarding the statement of Deficiencies dated November 8th, 2017. This Plan of Correction is not to be construed as an admission of or 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. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

10 NCAC 13F.1004 Medication Administration – Type B

Medication reorder In-Service with all med techs was conducted on 11-9-2017. "How to Reorder Medications" for outside pharmacy. Medication refills for Residents not using Neil Medical Pharmacy. The med tech will reorder when they notice that the resident is down to a 5-day supply. The med tech will: 1. Call the Pharmacy that provided the medication and let them know what medication the resident will be needing. The med tech will document and include the date/time and quantity remaining at the time of reorder. 2. The med tech will pass along the 24 Hour Report that they have attempted to reorder medication and when they are expected to be delivered. 3. If it has been more than 24 hours the med tech will refax the pharmacy and call them. If the med tech is having trouble obtaining meds from the pharmacy they should notify the RCC/HWD or SIC and they will follow-up. 4. Anytime a med tech is unable to administer a medication because the med is not available they will immediately notify the RCC/HWD. Brookdale pharmacy, Neil Medical can fill the order for a short period of time in most circumstances.

HWD and RCC to complete weekly cart audits on all carts to ensure all medications are available for administration.

New Order Tracking Form Checklist to be monitored on a daily basis by the HWD or the RCC.

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

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

It is the practice of this community to fully respect residents' rights and to provide care and services which are adequate, appropriate and in compliance with relevant federal and state laws and regulations. Staff was retrained on 11/9/2017.

10 NCAC 13F .0904(e) Nutrition and Food Service

In-Service conducted on 12/1/2017 for kitchen staff and dining room servers. All diets were discussed with staff. A listing with each resident's name and diet order is posted in the kitchen. A listing is printed from Nutrition Tracker and printed each week. If any changes are made to a resident's diet a new Nutrition Tracker will be printed. It is the HWD or RCC responsibility to take any new diet orders to the dining room manager. Individual resident order sheets have been implemented to ensure accuracy of their diet. This sheet has the resident's name and diet listed on it. It is matched to the Nutrition Tracker.

Written copies of physician diet orders for each resident are provided to the kitchen. The Dining Services Manager makes sure that these physician orders are kept in a file or notebook in the kitchen.

The Dining Room Manager is to manage and follow-up with the kitchen and dining room servers daily to ensure the correct diets are going to the right residents and physician's orders are being followed.

Carol Whisnant

Carol Whisnant, Executive Director

12-20-2017

Date