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 _____	01/30/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on January 29-30, 2019.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents with a history of falls (Resident #2 & #6). The findings are: Review of the facility's "Falls Management Policy" revealed: -"A fall refers to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed." -"A fall risk evaluation is completed at the time of move in, admission, and thereafter to determine factors that could contribute to potential falls." -"Resident falls are noted in the resident's record." -"A witnessed or reported unwitnessed fall with or	D 270		

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without injury is reported in the incident and accident reporting system."
-"A post fall evaluation is completed to consider possible interventions to reduce the potential for future falls or injury."
-"Review the fall at the next stand up meeting."
-"Discuss the resident fall(s) at the next collaborative care review meeting."

1. Review of Resident #2's current FL2 dated 01/07/19 revealed:
-Diagnoses included diabetes mellitus, transient cerebral ischemic attack, hypertension, and vascular dementia with behavioral disturbances.
-The resident was documented as being semi-ambulatory.

Review of Resident #2's Care Plan dated 07/06/18 revealed:
-The resident was ambulatory with assistance using a walker.
-The resident required supervision with ambulation.
-The resident required assistance with transfers at times.
-The resident required extensive assistance with toileting.
-The resident required assistance with dressing.

Review of Resident #2's staff charting notes revealed:
-On 11/07/18 (exact time was not documented), the resident had an unwitnessed fall attempting to get out of bed in which no injuries occurred.
-On 11/23/18 at 8:50pm the resident had an unwitnessed fall trying to leave her room because it was too hot, falling backward hitting her head, the resident was sent to the emergency room.
-On 11/26/18 at 7:00pm the resident had an unwitnessed fall ambulating down the hall, falling

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over the top of her walker, cutting her knee and hitting her head, the resident was sent to the emergency room.
-On 12/13/18 at 10:05pm the resident had a witnessed fall walking down in the hallway, hitting her head and reopening the wound on her knee, and the resident was sent to the emergency room.
-On 12/19/18 at 12:06am, the resident had an unwitnessed fall, cutting her head open, injuring her left wrist, and the resident was sent to the emergency room.
-Resident #2 had five falls from 11/07/18 to 12/19/18 with four of the five falls resulting in visits to the emergency room.

Review of Resident #2's Incident and Accident Reports revealed:
-No incident report was documented for the resident's fall on 11/07/18.
-A report dated 11/28/18 for fall on 11/23/18 at 8:50pm documented details of the resident's unwitnessed fall, and her injuries.
-No incident report was documented for the resident's fall on 11/26/18.
-A report dated 12/19/18 for fall on 12/13/18 documented the details of the resident's witnessed fall, and her injuries.
-No incident report was documented for the resident's unwitnessed fall on 12/19/18.

Review of Resident #2's post fall evaluations from 11/07/18 to 12/19/18 revealed no post fall interventions were implemented to reduce the potential for future falls or injury.

Review of the facilities 11/01/18 to 01/29/19 stand up meeting minutes revealed no documentation of communication to staff of Resident #2's falls.

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D 270	Continued From page 3 Review of Resident #2's collaborative care meetings from 11/01/18 to 01/29/19 revealed no collaborative care meetings had been held to discuss Resident #2's falls. Interview with Resident #2 on 01/29/19 at 9:45am revealed: -She had broken her wrist, hit her head, and mouth when she had a fall. - "I don't know why I fell, I just remember waking up and my family member was there". Telephone interview with Resident #2's responsible party (RP) on 01/30/19 at 5:06pm revealed: -She knew Resident #2 had a lot of falls because the facility staff had made her aware of them. -She could not recall the date of the falls. -Resident #2 had falls with different injuries. -Resident #2 had gone to the hospital three times since the beginning of November 2018. -Resident #2 had gone to the hospital when she broke her wrist, had staples in her head, and stitches in her knee. -She had not met with anyone at the facility to discuss Resident #2's falls. -She had not requested a meeting with facility staff to discuss additional interventions to prevent falls. -The facility called her when Resident #2 had a fall, and she would go to the hospital. Interview with the first shift personal care aide (PCA) on 01/29/19 at 9:50am revealed: -When she was working, Resident #2 had not had a fall. -She checked on Resident #2 at least every two hours because she did not want her to fall. -Resident #2 would get up out of her bed without using her call bell.	D 270		

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D 270	Continued From page 4 -Sometimes Resident #2 would press her call bell because she wanted someone to come in her room to keep her company. -She tried not to leave Resident #2 in her room alone during her shift because she would try to get up without staff helping her. -Resident #2 could not independently use her wheelchair with the brace in place on her wrist. -When Resident #2 returned from the hospital she had checked on her every hour for the first few days. -No one instructed her to check on Resident #2 more than every two hours. Interview with the third shift PCA on 01/30/19 at 10:41am revealed: -She was working when Resident #2 had some of her falls. - "She's had some really bad falls". -She had checked on Resident #2 every two hours before she had fallen. -She had not been told to check on her more often. Interview with the first shift medication aide (MA) on 01/29/19 at 11:15am revealed: -She knew Resident #2 had a lot of falls with injuries. -She was responsible, along with the PCA, to check on all the residents every two hours. -Resident #2 had hourly checks for the first 72 hours after she came home from the hospital in December 2018. -She had not documented every two hour checks for Resident #2. -She had not been instructed to document every two hour checks. -No one had told her to do anything different to prevent Resident #2 from falling.	D 270		

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D 270	Continued From page 5 Interview with the Resident Care Coordinator (RCC) on 01/29/19 at 3:00pm revealed: -She knew Resident #2 had a history of falls. -She had reminded the staff to check on Resident #2 every two hours. -When Resident #2 had returned from the hospital, she had reminded the staff to check on her every hour for the first 72 hours. -She had told the staff to make sure Resident #2's call bell was within reach when she was left alone in her room. -She had not met with the Health and Wellness Director (HWD) and the Administrator to address any additional interventions to prevent Resident #2's falls. -She had not found time to routinely assess if the MAs and PCAs were checking on the residents every two hours. Interview with the HWD on 01/29/19 at 3:15pm revealed: -She knew Resident #2 had a history of falls with injures that had sent her to the hospital. -When Resident #2 had returned from the hospital, the staff had been instructed to check on the resident every hour for the first 72 hours. -The PCAs and MAs were not required to document every two hour or hourly checks on residents. -She had not made any further recommendations to continue hourly checks on Resident #2. -Resident #2 had a wheelchair because she could no longer use her walker with a brace on her wrist, and she was too weak to walk long distances. -After review of Resident #2's post fall evaluation, she had not considered any interventions to prevent more falls. -She had not met with the RCC or the Administrator to complete a collaborative care	D 270		

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review for Resident #2 to add any additional interventions or supervisions to prevent future falls.

Attempted telephone interview with Resident #2's primary care physician on 01/30/19 at 4:00pm was unsuccessful.

Refer to interview with the Administrator on 01/30/19 at 11:15am.

2. Review of Resident #6's current FL2 dated 11/27/18 revealed:
-Diagnoses included varicella-zoster infection, subdural hematoma, increased creatinine serum, facial cellulitis, stroke, chronic kidney disease, hypertension, stenosis of right carotid artery, and septic olecranon bursitis of left elbow.
-The resident was documented as being ambulatory.

Review of Resident #6's Care Plan dated 06/26/18 revealed:
-The resident was ambulatory without assistance using a walker or wheelchair.
-The resident needed supervision with ambulation.
-The resident needed assistance with transfers at times.
-The resident needed assistance with toileting.
-The resident needed assistance with dressing.

Review of Resident #6's staff charting notes revealed:
-On 10/29/18 (exact time was not documented), the resident had an unwitnessed fall trying to place drinks into his refrigerator, no injuries occurred.
-On 11/24/18 (exact time was not documented), the resident had an unwitnessed fall, and was

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found with a cut to his right forearm.
-On 12/10/18 (exact time was not documented), the resident had an unwitnessed fall, no injuries occurred.
-On 12/11/18 (exact time was not documented), the resident had an unwitnessed fall, with injury to his left forearm.
-On 12/23/18 (exact time was not documented), the resident had an unwitnessed fall, no injuries occurred.
-On 01/05/19 (exact time was not documented), the resident had an unwitnessed fall, and was found with a small skin tear.
-Resident #6 had six falls from 10/29/18 to 01/05/19 with three of six resulting in injury.

Review of Resident #6's Incident and Accident Reports revealed no documentation of Resident #6's falls.

Review of Resident #6's post fall evaluation revealed on 01/07/19 the resident was placed on hourly checks, and referred to home health for physical therapy.

Review of the facility's 11/01/18 to 01/29/19 stand up meeting minutes revealed no documentation of communication of Resident #6's falls.

Review of Resident #6's collaborative care meetings from 11/01/18 to 01/29/19 revealed no collaborative care meetings had been held to discuss Resident #6's falls.

Interview with Resident #6 on 01/30/19 at 10:45am revealed:
-He had cut his arm and he could not remember how he had done it.
-"I ask these people for help when I need help, but I don't always need their help."

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D 270	Continued From page 8 Telephone interview with Resident #6's responsible party (RP) on 01/30/19 at 3:30pm revealed: -She knew Resident #6 had 3 or 4 falls. -She could not recall the date of the falls. -Resident #6 had falls when he got weak and his legs gave out on him. -When he has fallen he had cuts and some bruises. -Resident #6 has never been sent to the hospital. -Resident #6 got a wheelchair recently but she was not sure he was using it all of the time. -She was told the staff would check on him every hour to try and catch him before he fell. Observation on 01/30/19 from 11:00am to 12:45pm revealed: -Resident #6 was in his room in his recliner, up into his bathroom, and standing at his refrigerator independently. -No staff were observed in the resident's room. -No staff entered into his room to check on the resident. -No staff passed resident's room to look into his room. -One personal care aide (PCA) was observed sitting in the dining room at the end of the hallway away from the resident's room. -Another PCA was observed in the other dining room in another part of the building assisting resident's with their meals. Interview with the personal care aide (PCA) sitting in the dining room at the end of Resident #6's hallway on 01/30/19 at 12:30pm revealed: -She was assisting other residents with lunch service. -When she was working, Resident #6 had not had a fall.	D 270		

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D 270	Continued From page 9 -She was supposed to check on Resident #6 every hour. -She had not checked on him for at least two hours. -She had last checked on Resident #6 at approximately 10:30am. -She was supposed to enter Resident #6's room, ensure his call bell was within reach, assist him with toileting, and transfers if needed from his chair. -She was "tag teaming" his hourly checks with the other PCA on the hall. -She had not been instructed to document Resident #6's hourly checks. Interview with the PCA assisting residents in the main dining room on 01/30/19 at 1:00pm revealed: -She knew Resident #6 had hourly checks to prevent falls. -She was told to get all of the residents into the dining room and assist with lunch service. -She did not know the PCA left on the hall was not checking Resident #6 hourly. Interview with the first shift medication aide (MA) on 01/30/19 at 1:15pm revealed: -She knew Resident #6 had a lot of falls with injuries. -Resident #6 was supposed to be checked on every hour. -When she was off the floor, the PCAs were responsible for Resident #6's hourly checks. -The PCAs and MAs were both responsible for ensuring the residents were check on at least every two hours. -There was no set schedule for which PCA or MA was to check on an assigned resident. Interview with Resident Care Coordinator (RCC)	D 270		

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D 270	Continued From page 10 on 01/29/19 at 3:00pm revealed: -She knew Resident #6 had a history of falls. -She had reminded the staff to check on Resident #6 every hour. -She did not know the PCAs were not checking on Resident #6. -She had told the staff to make sure Resident #6's call bell was within reach when he was left alone in his room, and remind him to use it. -She had not met with the Health and Wellness Director (HWD) and the Administrator to address any additional interventions to prevent Resident #6's falls. -She had not found time to routinely assess if the MAs and PCAs were checking on the resident #6 every hour. Interview with the HWD on 01/29/19 at 3:15pm revealed: -She knew Resident #6 had a history of falls with injuries. -Resident #6 had been placed on hourly checks after his most recent fall on 01/07/19. -She had not met with the RCC or the Administrator to complete a collaborative care review for Resident #6 because they had not had the time. Telephone interview with Resident #6's Primary Care Physician on 01/30/19 at 4:24pm revealed: -He had seen Resident #6 after his fall on 01/07/19. -He had ordered a wheelchair and physical therapy. -The resident required more assistance and supervision to prevent falls because he had increased weakness. Refer to interview with the Administrator on 01/30/19 at 11:15am.	D 270		

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D 270	Continued From page 11 Interview with the Administrator on 01/30/19 at 11:15am revealed: -He knew the residents who had recurrent falls. -The staff had not communicated as a team about the management of the falls. -Communication of residents with falls and how the staff was to manage the falls had not been discussed during daily stand up meetings. -Collaborative care review meetings had not been completed by the HWD and himself to discuss any additional interventions to meet the residents current care needs and supervision. The facility failed to provide adequate supervision for 2 of 2 sampled residents with a history of falls related to Resident #2 & #6, Resident #2 with a recent history of falls who had 5 falls in 43 days, with 2 falls resulting in injuries resulting in 3 local emergency department visits, and Resident #6 with 6 falls in two months and 3 of 6 resulting in injury. This failure was detrimental to the residents' health, safety and welfare and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/30/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 16, 2019.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs	D 273		

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D 273	Continued From page 12 of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 2 of 5 sampled residents (Resident #3 and #4) with finger stick blood sugar readings outside of ordered parameters (#3) and amlodipine not administered as ordered (#4). 1. Review of Resident #4's current FL-2 dated 02/09/18 revealed: -Diagnoses included hypertension and congestive heart failure. -There was a medication order for amlodipine 10mg one tablet daily [(a medication used to treat high blood pressure (BP)]. Review of Resident #4's physician's orders dated 10/01/18 revealed there was a medication order for amlodipine 10mg one tablet daily. Review of Resident #4's January 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for amlodipine 10mg one tablet to be administered at 8:00am daily. -There was documentation amlodipine was not administered for 12 of 29 opportunities. -There was documentation amlodipine was not administered on 01/13/19, 01/15/19, 01/16/19, 01/17/19, 01/22/19, 01/23/19 and 01/24/19 due to "out of stock." -There was documentation amlodipine was not	D 273		

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administered on 01/14/19, 01/19/19, 01/20/19, 01/21/19 and 01/25/19 due to "on order."
-There was an entry to check blood pressure (BP) one time monthly on the 5th.
-Resident #4's BP was documented as 151/65 on 01/05/19.

Review of Resident #4's resident log in both his record and the facility's 24 hour reporting binder revealed no documentation Resident #4's primary care provider (PCP) had been notified regarding amlodipine not being administered.

Review of the facility's fax binder revealed no documentation a fax had been sent to Resident #4's PCP notifying him of amlodipine not being administered.

Observation of Resident #4's medications on hand on 01/30/19 at 3:00pm revealed amlodipine 10mg was available for administration.

Interview with a medication aide (MA) on 01/30/19 at 3:17pm revealed:
-Resident #4 had been out of amlodipine from 01/13/19 through 01/25/19.
-She had documented seven times in January 2019 Resident #4 was not administered his amlodipine.
-She "kept calling" the pharmacy asking where Resident #4's amlodipine was and each time a representative at the pharmacy would tell her it had already been dispensed to the facility.
-She was cleaning around the medication carts on 01/26/19 and found Resident #4's amlodipine punch card on the floor underneath one of the carts.
-She administered the amlodipine to Resident #4 at his next scheduled dose on 01/26/19 at 8:00am.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-She could not recall notifying Resident #4's PCP regarding amlodipine not administered.
-The MAs were to notify the PCP if a resident missed one dose of medication, but in Resident #4's case, she had not thought to notify the PCP because she was still trying to locate the amlodipine.
-If Resident #4's PCP had been contacted, there should be documentation in Resident #4's resident log in either his record or the facility's 24 hour reporting binder.
-If a fax notification had been sent to Resident #4's PCP, the fax confirmation and a copy of the fax would be in the facility's fax binder.

Interview with the Administrator on 01/30/19 at 3:45pm revealed:
-He did not know Resident #4 had missed any doses of amlodipine.
-He expected MAs to notify the PCP within 24 hours of a missed dose of medication and document the contact in the resident log.

Interview with Resident #4 on 01/30/19 at 4:15pm revealed:
-He did not know he had missed his dose of amlodipine for 13 days.
-He had felt "alright, he guessed."

Interview with the Health and Wellness Director (HWD) on 01/30/19 at 4:30pm revealed:
-She did not know Resident #4 had missed any doses of amlodipine.
-The MAs were responsible for reporting to the RCC and her after a resident missed one dose of medication.
-The MAs were responsible for notifying the PCP when a resident missed one dose of medication.
-The MAs were to notify the PCP by calling him and documenting the call in the resident's log.

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D 273	Continued From page 15 -The MAs were also to fax the PCP and attach the fax confirmation to a copy of the fax and file it in the fax binder. Telephone interview with a nurse from Resident #4's primary care provider's (PCP) office on 01/30/19 at 4:38pm revealed: -Resident #4 was prescribed amlodipine due to his history of high BP. -She did not know Resident #4 had missed 13 doses of amlodipine. -In looking back at her records, she found Resident #4's BP had worsened during the time he had missed the amlodipine. -During her visit with Resident #4 on 01/14/19, his BP was 104/72. -During her most recent visit with Resident #4 on 01/24/19, his BP was 128/80. -The PCP expected to be notified if a resident had missed two doses of any medication. Telephone interview with a representative from the facility's contracted pharmacy on 01/30/19 at 5:07pm revealed: -The pharmacy had dispensed 30 tablets of amlodipine 10mg for Resident #4 on 01/09/19. -The pharmacy had received a faxed order refill request from the facility on 01/19/19, 01/21/19 and 01/22/19. -The pharmacy faxed an "early refill request form" back to the facility on 01/19/19, 01/21/19 and 01/22/19 alerting them Resident #4's insurance company would not allow the pharmacy to refill the amlodipine again until 02/01/19. -The pharmacy requested the facility to review their refill request to assure it was not sent to the pharmacy in error and indicate on the "early refill request form" if they wanted the pharmacy to dispense the amlodipine and bill Resident #4. -The pharmacy received the "early refill request	D 273		

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form" back from the facility three times, but the forms were blank so the pharmacy could not dispense the amlodipine again for Resident #4.

2. Review of Resident #3's current FL-2 dated 06/18/18 revealed:
-Diagnoses included Type 2 diabetes mellitus.
-There was an order to monitor finger stick blood sugars (FSBS) three times daily and notify the primary care physician (PCP) if greater than 300 or less than 70.

Review of Resident #3's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to monitor FSBS three times daily before meals scheduled for 7:30am, 11:30am and 4:30pm and to notify the PCP if greater than 300 or less than 70.
-There was documentation Resident #3's FSBS was greater than 300 on two occasions.
-There was documentation Resident #3's FSBS was 331 on 12/22/18 at 11:30am and 306 on 12/24/18 at 11:30am.

Review of Resident #3's January 2019 eMAR revealed:
-There was an entry to monitor FSBS three times daily before meals scheduled for 7:30am, 11:30am and 4:30pm and to notify the PCP if greater than 300 or less than 70.
-There was documentation Resident #3's FSBS was greater than 300 on two occasions.
-There was documentation Resident #3's FSBS was 307 on 01/26/19 at 11:30am and 310 on 01/27/19 at 11:30am.

Review of Resident #3's resident log in both her record and the facility's 24 hour reporting binder revealed no documentation Resident #3's PCP

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had been notified regarding FSBS readings greater than 300.

Review of the facility's fax binder revealed no documentation a fax had been sent to Resident #3's PCP notifying him of FSBS readings greater than 300.

Interview with a medication aide (MA) on 01/30/19 at 3:17pm revealed:
-She knew Resident #3 had an order to notify her PCP if her FSBS reading was greater than 300 because the parameters were documented with the order to check FSBS.
-She could not recall Resident #3's FSBS reading ever being greater than 300.
-If Resident #3's PCP had been contacted regarding FSBS readings greater than 300, there should be documentation in Resident #3's resident log in either her record or the facility's 24 hour reporting binder.
-If a fax notification had been sent to Resident #3's PCP, the fax confirmation and a copy of the fax would be in the facility's fax binder.

Interview with the HWD on 01/30/19 at 4:30pm revealed:
-The MAs were responsible for notifying the PCP regarding FSBS readings outside of ordered parameters.
-The MAs were to notify the PCP by calling them and documenting the call in the resident's log.
-They were also to fax the PCP and attach the fax confirmation to a copy of the fax and file it in the fax binder.
-No one was double checking behind the MAs to assure they contacted the PCP as ordered.

Attempted telephone interview with Resident #3's PCP on 01/30/19 at 4:49pm was unsuccessful.

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D 273	Continued From page 18 Interview with the Administrator on 01/30/19 at 3:45pm revealed: -He did not know Resident #3's FSBS reading had been greater than 300 on four occasions in December 2018 and January 2019 and her PCP had not been notified as ordered. -He expected MAs to notify the PCP regarding FSBS readings outside of ordered parameters and document the contact in the resident log. -It was the HWD's responsibility to audit the eMARs and the resident logs to assure PCP's were notified when needed.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure the areas in the kitchen including the walls and floors, exit doors, refrigerator and freezer were kept clean and free of contamination. The findings are: Observations of the kitchen and store room on 01/29/19 at 11:10am through 11:50am revealed: -There were dark brown marks and splatter spots on the wall and door frame going into the dining room. -There were brown streaks and splatter marks on	D 282		

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the wall behind the sink closest to the dining room.
-There was a heavy build up of grease and debris on the floor with 2 fry baskets with green handles sitting on the floor between the stove and the freezer .
-The tiles in front of the entire length of the freezer and refrigerator were stained with a wet brown substance.
- The floors in the kitchen and the store room had food crumbs and the floors were sticky in places when as you were walking across the floor.
-There were white drip marks on the outside of the refrigerator and freezer doors.
-There were numerous white drip marks and white splatter marks on the inside door and inside side wall of the refrigerator closest to the dining room.
-There were brown, pink and white food crumbs in the bottom of the freezer closest to the back door.
-The gray seal around the freezer door had a brownish black substance on it .
-The stove had yellow and brown streaks on the sides and front of the stove.

Review of the facility kitchen sanitation report dated 10/10/18 revealed a score of 98.5.

Review of the kitchen cleaning schedule entitled "Sanitation and Project Management" schedule revealed:
-The schedule was for daily cleaning schedule for each shift.
-There were no staff initials that the cleaning had been done.
-The floors were to be swept and mopped by the evening cook daily and they were to initial the task was completed.
-The evening cook was to clean under the store

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D 282	Continued From page 20 room racks daily. -The evening cook was to clean the kitchen walls each Sunday and the ovens on Mondays each week. -No one was assigned to clean the inside of the refrigerators or freezers. Interview with the Dietary Manager (DM) on 0/29/19 at 11:15am revealed: -Neither he or the staff swept or moped until the end of the day. -The staff had a cleaning schedule they followed. -He was responsible for making sure the cleaning was being done. -It had been about three months since the staff had cleaned behind the equipment. -He needed to pressure wash the kitchen but he had just not had the time nor the opportunity. -"We did just sweep." -"We have not been doing our due diligence." -"There is always room for improvement." Interview with the Administrator on 01/30/19 at 12:02pm revealed: -"The cleaning needs to be done." -He expected immediate action when there were issues or concerns. -He was in agreement with the DM that the kitchen needed to be pressured washed. -He was aware of the cleaning schedule, he was not aware of who was to do the cleaning or if it was documented.	D 282		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes:	D 283		

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D 283	Continued From page 21 (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure food and beverages being stored by the facility were protected from contamination. The findings are: Review of the facility kitchen sanitation report dated 10/10/18 revealed: -A score of 98.5. -A 1.5 demerit was received for date marking and disposition of food. -A package of ham, turkey and cheese were not date marked and leaking on to other food items in the reach in cooler during the inspection. Observations of the dry goods pantry on 01/29/19 at 11:10am revealed: -There was a 5 pound (lb.) bag of pancake mix had been opened, closed in a gallon freezer bag but not dated. -There was a 2 lb. bag of croutons had been opened and then sealed with plastic wrap but not dated. -There was a 10 ounce (oz.) bag of croutons was half full in a gallon size freezer bag but not dated. -There was a loaf of whole wheat bread had been opened and tied closed with 7 slices remaining but was not dated. -There was a bag with 6 hamburger buns had been opened, tied closed but was not dated. -There was a 5 lb bag of Devil's food cake mix was half full sealed but not dated. Observation of the inside of the freezer on	D 283		

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D 283	Continued From page 22 01/29/19 at 11:12am revealed: -There was a clear plastic bag that had been opened half full of frozen biscuits not dated. -There were 6 individual pepperoni pizzas in a clear plastic bag that had been opened, tied closed and had not been dated. Observation of the inside of the refrigerator on 01/29/19 at 11:14 am revealed: -There was a clear container with a chicken salad, opened, not labeled nor dated. -There was a clear plastic container containing 6 tomato slices not dated or labeled. -There was a clear plastic container with a warped lid, almost full, containing a thick white cream, open and exposed. -There was a gallon freezer bag half full of cheddar cheese opened and not dated nor labeled. -There was a clear plastic container with a warped lid containing chocolate pudding, mostly full, not dated or labeled; the DM took it out of the refrigerator and placed in the dirty dish bin. -There was a head of lettuce in a long plastic bag not sealed, dated nor labeled. Interview with the Dietary Manager (DM) on 01/29/19 at 11:15am revealed: -Everything was to be dated and labeled before placing it in the pantry, refrigerator or freezer. -He was responsible for training staff to date and label items. -He had trained present staff on dating, labeling and rotating stock. -"We have not been doing due diligence." -"There is always room for improvement." Interview with the Administrator on 01/20/19 at 12:02pm revealed: -He expected immediate action when there were	D 283		

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D 283	Continued From page 23 any issues or concerns. -"My expectation is that there should be nothing in that kitchen that should not be dated and labeled.	D 283		
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 medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents related to Humalog (Resident #3) and amlodipine (Resident #4). 1. Review of Resident #4's current FL-2 dated 02/09/18 revealed: -Diagnoses included hypertension and congestive heart failure. -There was a medication order for amlodipine	D 358		

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D 358	Continued From page 24 10mg one tablet daily [(a medication used to treat high blood pressure (BP)]. Review of Resident #4's physician's orders dated 10/01/18 revealed there was a medication order for amlodipine 10mg one tablet daily. Review of Resident #4's December 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for amlodipine 10mg one tablet to be administered at 8:00am daily. -There was documentation amlodipine was administered for 31 of 31 opportunities. Review of Resident #4's January 2019 eMAR revealed: -There was an entry for amlodipine 10mg one tablet to be administered at 8:00am daily. -There was documentation amlodipine was not administered for 12 of 29 opportunities. -There was documentation amlodipine was not administered on 01/13/19, 01/15/19, 01/16/19, 01/17/19, 01/22/19, 01/23/19 and 01/24/19 due to "out of stock." -There was documentation amlodipine was not administered on 01/14/19, 01/19/19, 01/20/19, 01/21/19 and 01/25/19 due to "on order." -There was an entry to check blood pressure (BP) one time monthly on the 5th. -Resident #4's BP was documented as 151/65 on 01/05/19. Observation of Resident #4's medications on hand on 01/30/19 at 3:00pm revealed amlodipine 10mg was available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 01/30/19 at 5:07pm revealed:	D 358		

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D 358	Continued From page 25 -The pharmacy had dispensed 30 tablets of amlodipine 10mg for Resident #4 on 01/09/19. -The pharmacy had received a faxed order refill request from the facility on 01/19/19, 01/21/19 and 01/22/19. -The pharmacy faxed an "early refill request form" back to the facility on 01/19/19, 01/21/19 and 01/22/19 alerting them Resident #4's insurance company would not allow the pharmacy to refill the amlodipine again until 02/01/19. -The pharmacy requested the facility review their refill request to assure it was not sent to the pharmacy in error and indicate on the "early refill request form" if they wanted the pharmacy to dispense the amlodipine and bill Resident #4. -The pharmacy received the "early refill request form" back from the facility three times, but the forms were blank so the pharmacy could not dispense the amlodipine again for Resident #4. Interview with Resident #4 on 01/30/19 at 4:15pm revealed: -He did not know he had missed his dose of amlodipine for 13 days. -He had felt "alright, he guessed." Interview with a medication aide (MA) on 01/30/19 at 3:17pm revealed: -Resident #4 had been out of amlodipine from 01/13/19 through 01/25/19. -She had documented seven times in January 2019 Resident #4 was not administered his amlodipine. -She "kept calling" the pharmacy asking where Resident #4's amlodipine was and each time a representative at the pharmacy would tell her it had already been dispensed to the facility. -She had reported it to the Health and Wellness Director (HWD) and the Resident Care Coordinator (RCC).	D 358		

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-Both she and the RCC had searched all the medication carts and the "overstock" area and could not locate Resident #4's amlodipine.
-She was cleaning around the medication carts on 01/26/19 and found Resident #4's amlodipine on the floor underneath one of the carts.
-She administered the amlodipine to Resident #4 at his next scheduled dose on 01/26/19 at 8:00am.

Interview with the RCC on 01/30/19 at 4:30pm revealed she did not know Resident #4 had missed any doses of amlodipine.

Interview with the HWD on 01/30/19 at 4:30pm revealed:
-She did not know Resident #4 had missed any doses of amlodipine.
-The MAs were responsible for reporting to the RCC and the HWD after a resident missed one dose of medication.
-She had requested in the past, MAs wait until they had down time before attempting to stock the medications so they could take their time and avoid these types of incidents.
-No one routinely audited the eMARs to check for medications not administered.
-It was her responsibility to audit the eMARs, but she had not done so since she began working at the facility the first week of November 2018, due to being so busy with other tasks.

Telephone interview with a nurse from Resident #4's primary care provider's (PCP) office on 01/30/19 at 4:38pm revealed:
-Resident #4 was prescribed amlodipine due to his history of high BP.
-She did not know Resident #4 had missed 13 doses of amlodipine.
-Resident #4 missing amlodipine could cause him

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 _____	01/30/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 27	D 358		

to have rebound hypertension (a condition of elevated BP when medications were abruptly stopped).
-In looking back at her records, she found Resident #4's BP had worsened during the time he had missed the amlodipine.
-During her visit with Resident #4 on 01/14/19, his BP was 104/72.
-During her most recent visit with Resident #4 on 01/24/19, his BP was 128/80.

Interview with the Administrator on 01/30/19 at 3:45pm revealed:
-He did not know Resident #4 had missed any doses of amlodipine.
-He expected MAs to notify the RCC and HWD after the resident had missed two doses of medication.
-It was the RCC and HWD's responsibility to notify him when a resident had missed two doses of medication.
-The MAs should have searched for the missing amlodipine, and if it could not be located, they should have contacted the PCP for guidance.

2. Review of Resident #3's current FL-2 dated 06/18/18 revealed:
-Diagnoses included Type 2 diabetes mellitus.
-There was a medication order for Humalog 100units/mL inject 4 units every morning (a rapid acting insulin used to help control blood glucose in people with diabetes).
-There was an order to monitor finger stick blood sugars (FSBS) three times daily and notify the primary care physician (PCP) if greater than 300 or less than 70.

Review of Resident #3's December 2018 electronic Medication Administration Record (eMAR) revealed:

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	HAL036012	A. BUILDING: _____ B. WING _____	01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 28 -There was an entry for Humalog 4 units to be administered at 8:00am daily. -There was an entry to monitor FSBS three times daily before meals scheduled for 7:30am, 11:30am and 4:30pm and to notify the PCP if greater than 300 or less than 70. -There was documentation Humalog 4 units was not administered for four of thirty-one opportunities. -There was documentation Humalog 4 units was not administered on 12/03/18 due to "FSBS was less than 125" with documentation the FSBS reading was 118 at 7:30am. -There was documentation Humalog 4 units was not administered on 12/11/18 due to "FSBS was less than 120" with documentation the FSBS reading was 119 at 7:30am. -There was documentation Humalog 4 units was not administered on 12/12/18 due to "FSBS was 115" with documentation the FSBS reading was 115 at 7:30am. -There was documentation Humalog 4 units was not administered on 12/25/18 due to "FSBS was less than 120" with documentation the FSBS reading was 95 at 7:30am. -There was documentation of the following FSBS readings at 11:30am: 217 on 12/03/18, 226 on 12/11/18, no reading on 12/12/18, and 223 on 12/25/18. -FSBS readings for December 2018 ranged from 95 to 331. Review of Resident #3's January 2019 eMAR revealed: -There was an entry for Humalog 4 units to be administered at 8:00am daily. -There was an entry to monitor FSBS three times daily before meals scheduled for 7:30am, 11:30am and 4:30pm and to notify the PCP if greater than 300 or less than 70.	D 358		

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-There was documentation Humalog 4 units was not administered for one of twenty-nine opportunities.
-There was documentation Humalog 4 units was not administered on 01/02/19 due to "FSBS was 118" with documentation the FSBS reading was 118 at 7:30am.
-There was documentation the FSBS reading was 204 at 11:30am on 01/02/19.
-FSBS readings for January 2019 ranged from 70 to 310.

Observation of Resident #3's medications available for administration on 01/30/19 at 2:42pm revealed Humalog 4 units was available for administration.

Interview with Resident #3's responsible party on 01/29/19 at 9:30am revealed:
-He visited Resident #3 "often" at the facility.
-He did not think the resident was getting her Humalog as ordered because he had been in her room recently (could not remember date) for three and one half hours and the medication aide (MA) never administered her Humalog.
-He had spoken with the Administrator regarding his concerns, but had not heard back from him.

Interview with a MA on 01/30/19 at 2:42pm revealed:
-She did not think Resident #3 had an order to hold the resident's Humalog for any reason.
-When she pulled the Humalog 4 units order up on her computer screen, she saw a note to hold the Humalog if Resident #3's FSBS was less than 120, but she had never noticed the note before while administering medications so she had never held Resident #3's Humalog.

Interview with a second MA on 01/30/19 at

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D 358	Continued From page 30 3:17pm revealed: -She thought Resident #3 had an order to hold the Humalog 4 units if her FSBS was less than 120 because when she pulled the medication up on her computer screen, there was a note to do so. -Anytime Resident #3's FSBS was less than 120 at 7:30am, she did not administer her 8:00am dose of Humalog. Interview with the Health and Wellness Director (HWD) on 01/30/19 at 12:04pm revealed: -She could not locate an order to hold Resident #3's Humalog. -She was not sure why the order appeared on the MA's computer screen. -The facility's contracted pharmacy was responsible for entering information into the eMAR system. -No one routinely audited the eMARs to check for medications not administered. -It was her responsibility to audit the eMARs, but she had not done so since she began working at the facility the first week of November 2018, due to being so busy with other tasks. Attempted telephone interview with Resident #3's PCP on 01/30/19 at 4:49pm was unsuccessful. Interview with the Administrator on 01/30/19 at 3:45pm revealed: -He did not know why the MA's had held Resident #3's Humalog when her FSBS was less than 120 if they did not have an order to do so. -The HWD was responsible for auditing the eMARs so she could investigate whenever a medication was not administered.	D 358		

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D912	Continued From page 31	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents with a history of falls (Resident #2 & #6). [Refer to tag 270 10A NCAC 13F. 0901 (b) Personal Care and Supervision (Type B Violation)].	D912		