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 _____	R 05/02/2019

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 conducted a follow-up survey on May 1-2, 2019.	{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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure administration of medications as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (#3) related to a Parkinson's medication. The findings are: 1. Review of Resident #3's current FL2 dated 04/25/19 revealed:	{D 358}		

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{D 358}	Continued From page 1 -Diagnoses included muscle weakness, Parkinson's disease and hypoglycemia. -An order for Carbidopa-Levodopa 25-100mg four times a day. Review of Resident #3's physician's orders revealed: -A previous order dated 02/22/19 for Carbidopa-Levodopa 25-100mg three times a day. -An order dated 04/26/19 for Carbidopa-Levodopa 25-100mg 1-1/2 tablets four times a day. Review of Resident #3's March 2019 electronic Medication Administration Record (eMAR) revealed: -An order transcribed as Carbidopa-Levodopa 25-100mg three times a day documented as administered 03/01/19 at 8:00am - 03/28/19 at 2:00pm, three times a day. -An order transcribed as Carbidopa-Levodopa 25-100mg four times a day documented as administered 03/28/19 at 4:00pm - 03/31/19 at 8:00pm, four times a day. Review of Resident #3's April 2019 eMAR revealed: -An order transcribed as Carbidopa-Levodopa 25-100mg four times a day documented as administered 04/01/19 at 8:00am - 04/26/19 at 4:00pm, four times a day. -An order transcribed as Carbidopa-Levodopa 25-100mg 1- ½ tablets four times a day documented as administered 04/26/19 at 8:00pm - 04/30/19 at 8:00pm, four times a day. Review of Resident #3's May 2019 eMAR revealed: -An order transcribed as Carbidopa-Levodopa	{D 358}		

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{D 358}	Continued From page 2 25-100mg 1- ½ tablets four times a day documented as administered 05/01/19 at 8:00am and at 12:00pm four times a day. Observation of medications on hand for administration for Resident #3 on 05/01/19 at 12:00pm revealed: -There were 3 bubble packs with a dispense date of 03/28/19 of Carbidopa-Levodopa 25-100mg four times a day, with a quantity of 120 tablets, with 85 tablets remaining. -There was not a new label indicating an order change on the Carbidopa-Levodopa 25-100mg four times a day for the order change that started on 04/20/19 to administer 1-1/2 tablets four times a day. Interview with a medication aide (MA) on 05/01/19 at 12:00pm revealed: -The bubble packs with a dispense date of 03/28/19 was all that she had to use to administer the Carbidopa-Levodopa 25-100mg four times a day for Resident #3. -She did not know where the bubble packs of Carbidopa-Levodopa 25-100mg with a dispense date of 04/26/19 were located. Observation of the back stock supply of medication on 05/02/19 at 8:00am revealed: -There were 3 bubble packs with a dispense date of 04/20/19 of Carbidopa-Levodopa 25-100mg, with a quantity of 120 tablets, with 90 tablets remaining. Interview with a second MA on 05/02/19 at 8:00am revealed: -She found the bubble packs of Carbidopa-Levodopa 25-100mg in the "back stock supply" file cabinet in the medication room. -She did not administer any medications out of	{D 358}		

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{D 358}	Continued From page 3 those bubble packs. -The medications in that back stock cabinet were new medications for administering, medications to be returned to the pharmacy or medications that had a change in the order. -It was the policy to return all medication to the pharmacy with in a few days and not to place them in the back stock cabinet. -A "pharmacy return" form was to be filled out with the medication name, quantity to be returned, date, time and MA signature. -The medications to be returned were to be place in a tote with the return slip for the pharmacy to pick up, typically every other day. Telephone interview with a representative from the facility's contracted pharmacy on 05/02/19 at 9:08am revealed: -On 02/22/19 an order for Carbidopa-Levodopa 25-100mg three times a day and 90 tablets were dispensed to the facility on 02/22/19. -There were no Carbidopa-Levodopa 25-100mg tablets returned to the pharmacy by the facility. -On 03/28/19 an order was received for Carbidopa-Levodopa 25-100mg four times a day and 120 tablets were dispensed to the facility on 03/28/19. -On 04/20/19, 120 tablets of Carbidopa-Levodopa 25-100mg four times a day were dispensed to the facility. -The 120 tablets dispensed on 03/28/19 were to start on 03/29/19 and would have run out on 04/27/19. -The 120 tablets dispensed on 04/20/19 were to start on 04/28/19 and would have run out on 05/27/19. -Out of 240 tablets dispensed on 03/28/19 and 04/20/19 there should have been 97.5 tablets remaining if administered as ordered by the physician.	{D 358}		

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{D 358}	Continued From page 4 Interview with Resident #3's Neurology office on 05/01/19 at 2:09pm revealed: -She was the Medical Office Assistant for Resident #3's Neurologist. -Resident #3 was last seen in the office on 04/20/19. -The Neurologist increased the Carbidopa-Levodopa 25-100mg four times a day to 1-1/2 tablets four times a day. -Resident #3 reported to the Neurologist about increase in his tremors that were caused by the Parkinson's disease resulting in 2 falls. -The Neurologist increased the Carbidopa-Levodopa in order to decrease Resident #3's Parkinson's symptoms and giving Resident #3 better mobility to decrease falls. -The Neurologist considered it detrimental if the Carbidopa-Levodopa was not taken as prescribed there would be an increased risk of injury related to falls. A second interview with a medication aide on 05/01/19 at 2:48pm revealed: -She administered Carbidopa-Levodopa 25/100mg to Resident #3 two times on her shift. -She knew about the increase to 1-1/2 tablets four times a day on 04/26/19. -She would cut a tablet in half. -She used the tablets from the 03/28/19 bubble pack. -She never used Carbidopa-Levodopa 25/100mg from a bubble pack that was dispensed on 04/20/19. -She had not sent any Carbidopa-Levodopa 25/100mg back to the pharmacy. -The Health and Wellness Director (HWD) and Resident Care Coordinator (RCC) were responsible for all medication cart audits and putting new medications from the pharmacy on	{D 358}		

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{D 358}	Continued From page 5 the medication carts. A second interview with a second MA on 05/02/19 at 8:00am revealed: -She was new to the facility and had only been working as a MA for 3 months. -All medications that were changed were to be removed from the medication cart and sent back to the pharmacy. -The HWD or RCC were responsible for all medications sent back to the pharmacy. -She administered Carbidopa-Levodopa 25/100mg to Resident #3, twice on her shift when she worked. -She administered Carbidopa-Levodopa 25/100mg 1-1/2 tablets this morning at 8:00am. -The order on the bubble pack of Carbidopa-Levodopa 25/100mg did not match the order on the eMAR. -She administered the Carbidopa-Levodopa 25/100mg according to the order in the eMAR and did not realize the label on the bubble pack was not the same and did not have the medication "order change" label on it. -When an order on the eMAR did not match the label on the bubble pack an "order change" label was to be put on the bubble pack. -She did not know the bubble pack that contained the Carbidopa-Levodopa 25/100mg was dispensed on 03/28/19, because she did not look at that on a regular basis. -The HWD and RCC were responsible for all medication cart audits to check out dated medications, medications that were discontinued and medications for residents that were no longer at the facility. -A medication cart audit had not been preformed since she was hired 3 months ago because the facility did not have and RCC and the HWD was taking care of other duties.	{D 358}		

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{D 358}	Continued From page 6 Interview with the HWD on 05/02/19 at 8:05am revealed: -She and the RCC were responsible for the medication cart audits on a weekly basis. -The last medication cart audit was performed by the pharmacy in January 2019. -The MAs were to use all of the older bubble packs first as long as the order had not changed. -She and the RCC were responsible for all medication received from the pharmacy and putting them in the medication carts. -She knew the order for Resident #3's Carbidopa-Levodopa was changed from 1 tablet, 4 times a day to 1-1/2 tablets, 4 times a day on 04/20/19. -She did not know the MAs were administering the Carbidopa-Levodopa 25/100mg from the 03/28/19 bubble packs instead of the 04/20/19 bubble packs. -She did not know there were "extra" Carbidopa-Levodopa 25/100mg tablets left over. -When the order changed from 1 tablet of the Carbidopa-Levodopa 25/100mg, 4 times a day to the 1-1/2 tablets, 4 times a day the remaining Carbidopa-Levodopa 25/100mg was to be sent back to the pharmacy and the new order faxed to the pharmacy by the MAs. -She did not know the old bubble pack for the Carbidopa-Levodopa 25/100mg was still on the medication cart. -She faxed the new order to the pharmacy, and requested Carbidopa-Levodopa 25/100mg, 1/2 tablets be sent to go with the Carbidopa-Levodopa 25/100mg tablets to administer together to make the Carbidopa-Levodopa 25/100mg 1-1/2 tablets four time a day as ordered. Interview with the Administrator on 05/02/19 at	{D 358}		

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{D 358}	Continued From page 7 8:05am revealed: -The HWD and the RCC were responsible for the medication cart audits to check for medication refills needed, expired medication, narcotic count and medications that needed to be sent back to the pharmacy on a weekly basis. -The HWD and the RCC were responsible for monthly eMAR audits to check for accuracy and orders. -He did not know the HWD and the RCC did not perform the weekly medication cart audits or the monthly eMAR audits. -All of the unused, outdated or old order bubble packs were to be returned to the pharmacy. -He expected the facility staff to perform the medication cart audits, eMAR audits and to return all "old ordered" medications to the pharmacy and to give the medication as ordered by the physician. Interview with Resident #3 on 05/02/19 at 10:26am revealed: -He took Carbidopa-Levodopa 25/100mg for the tremors caused by the Parkinson's disease. -He saw the Neurologist on 04/20/19 and the Carbidopa-Levodopa 25/100mg was increased from 1 tablet, 4 times a day to 1-1/2 tablets 4 times a day to decrease his tremors and to help prevent further falls. -He had a fall on 04/30/19 and was sent to the emergency room for a head injury and returned to the facility with sutures in the back top of his head. -His tremors had been worse in the mornings compared to last month. -The tremors now affected his eating and trying to hold the silverware steady. -It was difficult for him to walk because of the tremors. -In the past two weeks the MAs sometimes gave	{D 358}		

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{D 358}	Continued From page 8 him "1" tablet and sometime "1-1/2" tablet 4 times a day. -He thought the order kept changing. The facility failed to assure medications were administered as ordered for 1 of 6 sampled residents (#3) related to a medication used to control Parkinson's tremors to help prevent falls, resulting in another fall with a head injury. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/02/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 16, 2019.	{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:	{D912}		