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
	HAL060042	A. BUILDING: _____ B. WING _____	08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEDDINGTON PARK	2404 PLANTATION CENTER DRIVE MATTHEWS, NC 28105

(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 08/28/19-08/29/19.	D 000		
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 1 of 3 sampled residents (Resident #1) with diet orders for a texture modified diet. The findings are: Review of Resident #1's current FL-2 dated 08/14/19 revealed: -Diagnoses included Alzheimer's Disease and dysphagia (difficulty swallowing). -There was an order for a mechanical soft diet (texture modified diet). Review of the therapeutic diet list dated 08/15/19 revealed Resident #1 was to be served a texture modified diet. Review of the regular diet menu for lunch revealed residents on a regular diet should be served sour cream cucumber salad, fried shrimp, red beans and rice, steamed yellow squash, a flaky croissant and pineapple upside down cake.	D 310	1. Dining Services Coordinator or designee inserviced associates what is allowed for certain diets and what is not allowed. 2. Dining Services Coordinator or designee will hold standup meetings that will include discussion of specific diets and what can be served for the modified diets. 3. Dining Services Coordinator or designee inserviced kitchen staff regarding modified det with appropriate substitutions and correctly prepared according to the modification. 4. Executive Director or designee will audit diets to ensure we are following the proper guidelines for the diets.	9/5/19 9/5/19 Ongoing 9/5/19 9/5/19 Ongoing

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Fitchett — TITLE: Executive Director — (X6) DATE: 9/27/19

Reviewed and acknowledged gyp 10/2/2019

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D 310	Continued From page 1 Review of the therapeutic diet menu for lunch revealed residents on a texture modified diet should be served tomato juice instead of sour cream cucumber salad, ground fried shrimp with sauce, fluffy white rice without beans, tender, well-cooked squash, a flaky croissant with butter, and a soft vanilla cookie instead of pineapple upside down cake. Review of the therapeutic diet menu for lunch on 08/26/19 revealed residents on a texture modified diet should be served a baked potato with the peel removed and served with gravy. Observation of the lunch meal service on 08/28/19 from 12:00pm to 12:47pm revealed: -A medication aide (MA) served Resident #1 sour cream cucumber salad. -Resident #1 consumed a few bites without difficulty. -After prompting, the MA removed the cucumber salad from Resident #1's table and served her applesauce. -The MA attempted to serve Resident #1 a plate with ground shrimp covered in cocktail sauce, cut squash, a baked potato cut into quarters with the peel and without gravy, and a croissant. -Resident #1 ambulated in her wheelchair away from the table and did not eat. Interview with a MA on 08/28/19 at 12:45pm revealed: -She had served Resident #1 during the lunch meal service. -She served Resident #1 sour cream cucumber salad because she thought because the cucumbers were cut into small chunks, it was acceptable to serve them to someone on a texture modified diet. -No one had ever told her residents on a texture	D 310		

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D 310	Continued From page 2 modified diet should not have cucumber salad, and she was never provided a therapeutic diet menu to use as reference while serving meals. -She served Resident #1 the baked potato with the peel and without gravy because that is what she was told to do by the dietary staff who plated the food. Interview with the Dining Services Coordinator on 08/29/19 at 10:02am revealed: -He managed the kitchen and provided oversight for meal services. -Residents on a texture modified diet were typically served applesauce in place of any starter salads. -The MA made a mistake when she served cucumber salad to Resident #1. -He could not explain how the dietary servers were supposed to know what starters and what desserts should be served to residents on a texture modified diet. -The servers would come into the kitchen and request "a ground meat plate" whenever they were ready to serve residents on a texture modified diet their main course. -He and the cook knew, by referencing the therapeutic diet menu spreadsheet, to make any adjustments to the other foods on the plate as required. -He had plated a baked potato with the peel and without gravy for Resident #1 because he knew she did not like the fluffy white rice the texture modified diet menu called for. -He did not put gravy on the baked potato because he did not want to "smother" Resident #1's plate with sauces and/or gravy and the ground shrimp was served covered with cocktail sauce. -It was a "last minute decision" to serve the baked potato to Resident #1 so he did not take time to	D 310		

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D 310	Continued From page 3 reference the therapeutic diet menu to see the peel should be removed. Interview with Resident #1 on 08/29/19 at 11:08am revealed: -She thought she was on a regular diet. -She was usually served the same foods the other residents were served. -She did not know if she had ever had any problems with swallowing in the past. -She did not eat her lunch on 08/28/19 because she was not hungry. Telephone interview with Resident #1's Power of Attorney (POA) on 08/29/19 at 12:15pm revealed: -She knew Resident #1 was ordered a texture modified diet, but she did not know why. -As far as she knew, Resident #1 had never had any issues with swallowing or choking. -Resident #1 had recently returned to the facility from rehabilitation and may have been evaluated by speech therapy at the rehabilitation facility. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 08/29/19 at 11:05am was unsuccessful. Interview with the Administrator on 08/29/19 at 11:45am revealed: -She thought Resident #1 had returned to the facility after her rehabilitation stay with the diet order for texture modified. -Resident #1 had not received speech therapy services since she had returned to the facility, but she was on the schedule for an evaluation to be completed the next time the speech therapist visited the facility. -She did not know dining staff were not following the texture modified diet menu when serving residents but expected them to do so.	D 310		

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D 310	Continued From page 4 -She audited a meal service once weekly but did not refer to the menus to ensure the residents received only those foods listed as appropriate for their therapeutic diet.	D 310		
D 352	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed; (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date; (8) auxiliary statements as required of the medication; (9) the name, address, telephone number of the dispensing pharmacy; and (10) the name or initials of the dispensing pharmacist. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure Lantus insulin was properly labeled for 1 of 5 sampled residents (Resident #3). The findings are:	D 352	1. HWD or designee to inservice policy and expectations with Med Techs. 2. HWD, RCC or designee audit Med carts monthly and as needed along with spot checks. 3. HWD or designee instructed Med Techs when medications are received to double check the label to ensure it's labeled correctely. 4. Will instruct our pharmacy when they complete our pharmacy audit to make sure they also include checking for expired medications, medications are present and labeled correctly on the cart.	9/30/19 9/5/19 Ongoing 9/5/19 Ongoing 9/5/19 Ongoing

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D 352	Continued From page 5 Review of Resident #3's current FL2 dated 04/19/19 revealed: -Diagnoses included insulin dependent diabetes, seizure disorder, and hypothyroidism. -Medication orders included Novolog mix 70/30 (insulin used to control blood sugar levels) inject 19 units before breakfast and 17 units before supper. Observation of Resident #3's Novolog mix 70/30 insulin available in the medication cart on 08/29/19 at 8:40am revealed: -There were two Novolog insulin pens located in the top left drawer of the medication cart. -The Novolog pens were not inside a bag and did not have a pharmacy generated label. -The Novolog pens did not have Resident #3's name labeled on the pen or directions for administration. -One Novolog pen had a handwritten expiration date. -The second Novolog pen had no expiration date or date opened labeled on the pen. Review of the facility "Medications and Treatments Labeling Policy" revealed: -All medications and treatments should be labeled with the necessary information to provide safe medication management administration/assistance. -The medication label should be consistent with a physician/healthcare provider order and with applicable regulatory requirements. Interview with the medication aide (MA) on 08/29/19 at 8:45am revealed: -Resident #3 was the only resident who received insulin. -There were two opened Novolog mix 70/30 pens	D 352		

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D 352	Continued From page 6 for Resident #3 on the cart. -Another MA opened a second Novolog pen before finishing the other pen. -She did not know when the Novolog pens were opened. -She did not know when the Novolog pens were expired. -Another MA labeled one of the Novolog pens with an open date. -The MAs were responsible for labeling the Novolog pens with an open date. Interview with the Resident Care Coordinator (RCC) on 08/29/19 at 8:50am revealed: -The MAs were responsible for labeling the insulin pens with the date that it was opened. -The residents name and a "see instructions" label should be on the insulin pens to provide direction to the MAs. -She thought a new MA was responsible for not labeling the insulin pen for Resident #3 with the name and date opened. Interview with the Health and Wellness Director (HWD) on 08/29/19 at 11:52am revealed: -She had not noticed Resident #3's insulin pen was not labeled with the name, instructions, and date opened. -The MAs were responsible for labeling the insulin pens for the residents with the resident's name, instructions, and date opened. -One of the pens for Resident #3 was labeled with the resident's name in black marker. -The MAs should have made sure the date opened and the residents name was clearly indicated on the pen, "it was missed". -Medication cart audits were spot checked monthly and Resident #3's Novolog was not caught. -There needed to be a better process to make	D 352		

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D 352	Continued From page 7 sure the pens were labeled properly. Interview with the Administrator on 08/29/19 at 12:23pm revealed: -Medications were to be labeled with the resident's name and instructions before they were placed on the cart. -She expected the MAs to indicate the date opened on the insulin pens. -The RCC and HWD were responsible for auditing the medication carts monthly. -MAs should ask the RCC or HWD for a label with name, instructions, and a place to indicate date opened if it was not labeled.	D 352		
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:	D 358		

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D 358	Continued From page 8 Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 residents observed during the 8:00am medication pass on 08/29/19 at 8:15am as related to a medication used for abdominal discomfort (Resident #8). The findings are: The medication error rate was 9.3% as evidenced by the observation of 3 errors out of 32 opportunities during the 8:00am medication pass on 08/29/19. (Refer to tag 371). Review of Resident #8's current FL2 dated 06/07/19 revealed: -Diagnoses included gastro-espohageal reflux disorder (GERD). -There was an order for Prelief tablets 340 mg, a medication indicated to relieve GERD, three times a day. Observation of the 8:00am medication pass on 08/29/19 at 8:40am revealed: -The morning medication aide (MA) prepared 3 oral medications for administration to Resident #8. -The MA administered the 3 oral medications to Resident #8, with a 6 ounce cup of water. -There was an entry on the electronic Medication Administration Record (eMAR) for a fourth medication to be administered, Prelief, one tablet three times a day before meals. -The MA could not locate the blister pack of Prelief tablets to be administered to Resident #8. -Resident #8 was not administered Prelief 340mg tablet during the 8:00am medication pass. Review of Resident #8's August 2019 eMAR	D 358		

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D 358	Continued From page 9 revealed: -There was an entry for Prelief 340mg, to be administered three times daily before meals, scheduled for 8:00am as the morning dose. -Prelief was documented as administered at 8:00 am daily from 08/01/19 through 08/26/19. -Prelief was not documented as administered from 08/27/19 through 08/29/19. Observation of Resident #8's medications on hand for administration on 08/29/19 at 8:40am revealed there was no Prelief to be administered to Resident #8 on the medication cart or in the medication room. Interview with the medication aide (MA) on 08/29/19 at 10:20am revealed: -She did not know Resident #8's Prelief was not in the facility. -She did not know if the refill medication had been ordered through the pharmacy. -The MAs were responsible for reordering medications when there were 5 or less tablets in the blister pack. -The MAs could reorder medications from the facility pharmacy by using the software option on their medication cart computers, or fax a refill request to the pharmacy with the name of the resident and the medication. -It was the responsibility of the MAs to follow up with the pharmacy once a refill medication was ordered, until the medication arrived in the facility. -The MAs should report to the Resident Care Coordinator (RCC) or the Health and Wellness Director (HWD) if a medication had not been sent within 24 hours. -The MAs should report at shift change if there were medications waiting to be refilled and sent from the pharmacy.	D 358	1. Medications are ordered in PCC however we have added to pull stickers and put on clipboard/paper and med techs will mark off what was received. What wasn't received will be followed up by Med Tech and follow through each shift for follow-up as well as notify HWD, RCC or designee until the medication is received.	9/5/19 Ongoing

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D 358	Continued From page 10 Telephone interview with a representative from the contracted pharmacy on 08/29/19 at 11:30am revealed: -The pharmacy filled residents' medication orders based on information received directly from the residents' prescriber or from orders sent by the facility to the pharmacy. -The pharmacy sent 90 tablets, a 30 day supply of Prelief, to the facility for Resident #8 on 06/19/19 and 07/28/19. -The 90 tablets of Prelief sent on 07/28/19 would have been completed on 08/27/19. -A refill request for Prelief was sent from the facility today, 08/29/19. -Prelief 340mg, 90 tablets, to be administered 3 times a day before meals, would be delivered tonight with the medication tote. Interview with the Health and Wellness Director (HWD) and the Resident Care Coordinator (RCC) on 08/29/19 at 12:00pm revealed: -The MAs were responsible for the medications on their carts. -The MAs should reorder medications from the pharmacy when there are 7 or less tablets, unless insurance required a shorter window to reorder. -The MAs could reorder medications from their medication cart by using the software feature on their computers. -The MAs could also fill out a refill medication form and fax the refill request to the pharmacy with the resident's name and the name of the medication. -The MAs on subsequent shifts could view the refill history on the computer to determine if a medication had been ordered. -Once a refill medication was requested, each MA on the subsequent shifts should be "watching" to ensure the medication arrived at the facility. -If a medication had not arrived within 24 hours,	D 358		

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D 358	Continued From page 11 the MAs should contact the pharmacy. -The MAs should inform myself or the RCC if the medication was not in the facility in 2 days. -She did not know the Prelief refill order had not be sent from the pharmacy. -She did not know Resident #8 had missed 7 doses of the Prelief as of this morning. Interview with the Administrator on 08/29/19 at 12:15pm revealed: -The MAs were responsible for ordering refill medications. -The MAs were responsible for ensuring the medications prescribed by the physician and entered on the eMAR were on the medication cart. -She expected the MAs to contact the HWD or the RCC when they were not able to get medications in a timely fashion from the pharmacy. -She did not know Resident #8 had missed 7 doses of Prelief tablets. Attempted interview with Resident #8 on 08/29/19 at 2:10pm was unsuccessful. Interview with the primary care physician (PCP) on 08/29/19 at 2:47pm revealed: -Resident #8 was diagnosed with GERD and intestinal inflammation. -She was prescribed Prelief tablets before meals to assist in reducing the acid in the foods Resident #8 ate during her meals. - Less acid would reduce the abdominal discomfort and inflammation Resident #8 experienced after meals.. -She expected the facility staff to administer medications as prescribed.	D 358		

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D 371	Continued From page 12	D 371		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents as related to 2 of 2 medication aides not using appropriate hand hygiene techniques. The findings are: 1. Observation of the 8:00am medication pass on 08/29/19 at 8:05am through 8:44am revealed: - The medication aide (MA) applied gloves, and removed one tablet from a resident's bottle. -The MA removed her gloves, sanitized her hands and dispensed two additional tablets into the medication cup. -The third tablet dispensed dropped onto the medication cart counter top. -The MA applied gloves, removed the tablet from the countertop and placed it in the medication cup. Interview with the MA on 08/29/19 at 8:11am	D 371	1. HWD or designee to inservice the proper infection control protocol. Will also ensure this training is completed annually and as needed. 2. RCC, HWD or designee will complete spot checks with Med Techs to ensure proper infection control is done properly.	9/30/19 Ongoing 9/5/19 Ongoing

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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 371	Continued From page 13 revealed: -She knew she should waste a pill or tablet that fell to the floor. -She thought she could place it from the medication cart counter top to the medication cup. -She did not know it was contaminated. -She had been trained on infection control policies with the facility nurse. Review of the facility policy for Medication Administration revealed gloves should be worn when cutting tablets in half or touching them for other reasons (#11). Interview with the Resident Care Coordinator (RCC) on 08/29/19 at 11:55am revealed: -The MAs had all received infection control training before administering medications. -A medication that touches any surface aside from the medication cup when administering medications to a resident should be discarded. Interview with the Administrator on revealed 08/29/19 at 12:15pm revealed: -She did not know the MA was unaware that a medication fallen onto the medication cart countertop was contaminated. -It was the policy of the facility that any medication that fell from the blister pack onto another surface, should be wasted by the MAs. 2. A second medication aide (MA) removed 9 tablets from their blister packs into a medication cup for a resident. -The resident requested "that big pill" to be removed from the medication cup and administered to her separately. -The MA removed the "big pill" with her ungloved hand and placed it in a second medication cup.	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060042	A. BUILDING: _____ B. WING _____	08/29/2019

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D 371	Continued From page 14 -The resident requested the "other big pill" also be removed from the medication cup with 8 tablets. -The MA removed a second tablet from the medication cup containing 8 tablets, with her ungloved hand and placed it in a third medication cup. -The MA did not sanitize her hands before or after removing the 2 tablets from the medication cup of 9 tablets. Interview with the second MA on 08/29/19 at 8:45 revealed: -She forgot to separate the larger tablets from the rest of the medications for this resident. -The MA knew she should not touch medications with an ungloved hand. -She had attended the infection control training at the facility. Interview with the Resident Care Coordinator (RCC) on 08/29/19 at 11:55am revealed: -The MAs had all received infection control training before administering medications. -It was the policy of the facility that no medications were handled without gloves and proper hand sanitizing before and after administration. Interview with the Administrator on revealed 08/29/19 at 12:15pm revealed: -She did not know the MA handled medications without gloved hands. -It was the policy of the facility that medications were handled with gloved hands.	D 371		