STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036012	A. BUILDING: ADULT CARE LICENSURE SECTION RALEIGH B. WING	R 06/24/2021

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 a follow-up survey on 06/23/21 to 06/24/21.	{D 000}	ED or designee Will do additional training on medication administration, cart audits and proper procedure for ordering medication prior to it running out ED or designee will do weekly cart audits to assure that all medication are in house ED or designee put a system in place to check for reordered meds the day after reordering and follow up on a call to the pharmacy if the med did not come in as to why it didn't. The designee when the document in the chart.	7.24.21
{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 administer medications as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #5) related to not administering a medication to treat anxiety disorder. The findings are: Review of Resident #5's current FL2 dated 02/22/21 revealed: -The diagnoses included type 2 diabetes, chronic pain, insomnia, and bipolar disorder. -An order for Klonopin 1mg three times per day. Review of Resident #5's June 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Klonopin 1mg (clonazepam) 1 tablet three times a day for anxiety.	{D 358}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shumila Bolus — TITLE: Executive Director — (X6) DATE: 8/2/21

Reviewed and acknowledged on 9/23/21 Jennifer Fender RN / jbf

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{D 358}	Continued From page 1 -The eMAR listed the administration times as 8:00am, 2:00pm and 8:00pm. -The medication was not administered on 06/09/21 at 2:00pm through 06/11/21 at 2:00pm. -The number of doses missed were seven. -The reason documented as not administered was "unavailable from pharmacy". Interview with Resident #5 on 06/23/21 at 10:45am revealed: -She ran out of one of her medications one week ago. -The medication was Klonopin, which she took three times a day. Interview with Resident #5 on 06/24/21 at 2:30pm revealed: -She was taking the Klonopin for her anxiety. -She was also taking the Zoloft which helped a little for her anxiety. -She was out of the the Klonopin for several days. -She could tell that she was not getting the medication, but did not have to go to the hospital because of not getting it. Telephone interview with a representative for the facility's contracted pharmacy on 06/24/21 at 4:12pm revealed Resident #5's Klonopin 1mg three times daily was last dispensed on 06/11/21 for a quantity of 90, and on 05/07/21 for a quantity of 90. Attempted telephone interview with Resident #5's primary care provider was unsuccessful. Interview with a medication aide, MA on 06/24/21 at 1:18pm revealed: -There were reorder stickers on the controlled medications that alerted the staff when to reorder the medication.	{D 358}		

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{D 358}	Continued From page 2 -Generally, it was when there were 10 doses left. -They pulled the label with the order number, resident name and medication name off of the control card and faxed it to the pharmacy when the medication needed to be reordered. -If a new prescription needed to be written by the provider the pharmacy would take care of getting the new prescription written. -If the medication did not arrive they would check with the pharmacy to see why the medication had not been filled. -They would call the pharmacy, but they did not document the communication to the pharmacy. -There were problems at times getting the new prescriptions written. Interview with a second MA on 06/24/21 at 2:45pm revealed: -Only the provider who originally ordered the medication would write the prescription. -She had tried in the past, with other residents, to get different physicians to reorder medications, but they would not. -She had been told by the Administrator that if a medication was not available and the resident needed it, to give the resident the opportunity to go out to the hospital. -If a medication did not arrive when the current medication ran out, she would sometimes call the pharmacy to check on it and most of the time they were having problems getting the providers to write the prescription. -They did not document communication with the pharmacy. -The medications not being available continued to be a problem for the facility because the MAs had problems getting the providers to write the prescription. Telephone interview with the Administrator on	{D 358}		

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{D 358}	Continued From page 3 06/24/21 at 2:45pm revealed: -She became the Administrator in October 2020. -Typically the Resident Care Coordinator (RCC) should be auditing the eMARS and the orders at the end of the month against the medications on hand to prevent these types of errors. -She currently did not have an RCC. -The MAs should reach out to the physician via phone call or fax to request refills 10 days before a medication ran out. -There was a red sticker on the bubble packs to remind the MAs of the 10 day time frame. -The MAs should follow-up on all communication with physicians within 24-48 hours. -If medications were unavailable for administration she expected the MAs to document accordingly and to notify her.	{D 358}		