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BROOKDALE CHAPEL HILL	2230 FARMINGTON DRIVE CHAPEL HILL, NC 27514

(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 and follow-up survey on 05/23/19 - 05/24/19.	D 000		
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: (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 observations, interviews, and record review, the facility failed to assure foods were free from contamination related to open food packages that were not labeled or dated, foods not labeled or marked with an expiration date, uncovered food and leftover food not labeled or dated or properly cooled. The findings are: Observation of the dry storage pantry in the kitchen on 05/23/19 at 8:50 am revealed: -There were four plastic storage containers of dry cereal that were not dated or labeled. -There was an open round carton of dry oatmeal, a gallon of pancake syrup, and a box of cornbread mix that were opened and not dated with an open date. -There was a twenty-pound box of powdered food thickener that was opened and uncovered; the food thickener was not dated with an open date. Observation of the reach-in refrigerator on 05/23/19 at 9:05 am revealed:	D 283		

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D 283	Continued From page 1 -There was a plastic container stored on the bottom shelf that held diced potatoes and water, the container was not covered, dated or labeled. -There was a plastic container on a shelf that had water and fresh carrots, that was not covered, dated or labeled. -There was a metal pan that held gravy and an opened package of sliced deli turkey that were not covered, dated or labeled. -There was a pan of noodles, a pan of beef cacciatore, and a pan of soup that were not dated or labeled. -There were open packages of parmesan and shredded cheddar cheese that were not dated and labeled. -There was a one-gallon jug of tartar sauce, a one-gallon jug of Italian dressing, a one-gallon jug of sweet and sour sauce, 2 one-gallon jugs of milk that were not dated with an open date. -There was a pan of raw fish, a pan of fresh-pealed garlic in water and a pan of diced tomatoes that were not dated and labeled. Observation of the reach-in freezer on 05/23/19 at 9:10 am revealed there was half a pie, a half a loaf of pound cake, two half loaves of bread and a bag of onion rings that were not dated and labeled. Review of the most current NC Division of Environment Health sanitation report dated 03/13/2019 revealed: -The food service area had been inspected on 03/13/19 and received a score of 95. -The inspection report indicated observation of potentially hazardous food and ready to eat foods not properly dated and labeled. -Ready to eat foods not dated after opened with an open date.	D 283		

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D 283	Continued From page 2 Interview with a cook on 05/23/19 at 9:30 am revealed: -He knew leftovers and food in open containers needed to be covered, dated and labeled; he placed items in the refrigerator over night and had not had a chance to date or label anything. -He did not know ready to eat items needed a date on them once opened. Interview with a second cook on 05/24/19 at 9:35 am revealed: -He always covered, dated and labeled food after opening and before he stored anything, but he never checked the storage areas and refrigerators to make sure other food was dated. Interview with the dining service manager on 05/24/19 at 9:20 am revealed: -The cooks were required to cover, date and label all food and leftovers; he did not know ready to eat food that had been opened needed to be dated with an open date. -The cooks had stickers for dating and labeling food and had been trained on how to use them; he did not know why the stickers were not used by the cooks. -He checked on the kitchen everyday and looked for dates and labels; he had not had a chance to look at anything today, 05/24/19. Interview with the Administrator on 05/24/19 at 9:40 am revealed: -Leftover foods should never be saved and should be thrown out. -All food should be covered, labeled and dated when stored in the food pantry and in the refrigerator and freezers. -The cooks were provided with stickers for dating and labeling; she went into the kitchen everyday but did not look at food items for dates and labels	D 283		

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D 283	Continued From page 3 because that was the dining service manager's responsibility.	D 283		
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, interviews and record reviews the facility failed to assure nutritional supplements were served as ordered to 1 of 5 residents sampled (#5). The findings are: Review of Resident #5's FL2 dated 04/26/19 revealed: -Diagnoses included vascular dementia, constipation, hypothyroidism insomnia. -There was an order for Ensure (a nutritional supplement), give one can three times a day. Review of Resident #5's Resident Register revealed an admission date of 04/27/19. Review of the diet list dated 05/23/19 and time stamped at 10:42:21 revealed Resident #5 was not included on the nutritional supplement list. Review of the shift notes dated 04/27/19 revealed day shift had documented Resident #5 was a "new admit" and "awaiting clarification/nutritional supplement".	D 310		

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Review of a subsequent physician's order dated 05/24/19 at 12:12 pm revealed an order for a nutritional supplement drink one can three times per day after meals.

Observation of Resident #5's lunch meal on 05/23/19 from 12:06 pm to 12:30 pm revealed she was served water, cranberry juice, grilled cheese and pound cake with peaches; she did not receive a nutritional supplement with her meal.

Observation on 05/24/19 at 10:30 am of Resident #5's medication revealed there were no supplements on the medication cart for Resident #5.

Resident #5's April 2019 electronic Medication Administration Record (eMAR) was not available for review.

Review of Resident #5's May 2019 eMAR revealed there were no nutritional supplements listed on the eMAR for administering to Resident #5.

Based on observations, record reviews and interviews it was determined that Resident #5 was not interviewable.

Telephone interview with a representative from Resident #5's physician's office on 05/24/19 at 11:40 am revealed:
-The physician had ordered Resident #5 the nutritional supplement on 07/13/18 when she lived in another facility; the original order was to administer the nutritional supplement three times a day after meals and the order had never been changed.
-Resident #5 was seen by the physician on

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05/02/19 and the order was documented on the encounter to give Resident #5 the nutritional supplement three times a day after meals.

Interview with a medication aide (MA) on 05/24/19 at 11:40 am revealed:
-She did not know Resident #5 was ordered a nutritional supplement; if the nutritional supplement was not on the eMAR, she did not administer it to Resident #5.
-She had never administered nutritional supplements to Resident #5.
-She could enter new information on the eMAR when there was a new order or a new resident.
-The facility's Registered Nurse (RN) usually entered new information and orders for new residents when they were admitted to the facility.

Telephone interview with a second MA on 05/24/19 at 2:45 pm revealed she could not remember if Resident #5 was ordered a nutritional supplement or if she had ever served Resident #5 a nutritional supplement.

Interview with a third MA on 05/24/19 at 2:48 pm revealed she did not remember Resident #5 ever getting a nutritional supplement; it was not listed on the eMAR for her to give to Resident #5.

Telephone interview with the facility's RN on 05/24/19 at 5:45 pm revealed:
-She assisted with entering information and orders on the eMAR for new residents, but she could not remember if she had entered the information on the eMAR for Resident #5.
-MAs put in new orders and new admissions on the eMAR.
-Resident #5's nutritional supplement should have been on the eMAR if it was on her FL2.
-She tried to conduct eMAR audits every time

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D 310	Continued From page 6 assessments and quarterly reviews were conducted. -The Administrator had told her Resident #5 needed clarification of orders for the nutritional supplement about two weeks ago; the Administrator needed to know if the nutritional supplement was to be administered by mouth. -She had sent a clarification about the nutritional supplement order to Resident #5's physician about two weeks ago via fax; she did not have a copy of the fax. -She did not follow up with the physician after she sent the fax. Interview with the Administrator on 05/24/19 at 5:35 pm revealed: -The facility staff had called Resident #5's physician on 04/27/19 for clarification orders for the nutritional supplement order because they did not know if the nutritional supplement was to be administered by mouth. -The call to the physician for clarification was not documented; calls to the physicians were never documented and clarification requests were not faxed. -Clarification notes were documented on the shift reports.	D 310		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered;	D 367		

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D 367	Continued From page 7 (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the electronic Medication Administration Records for 1 of 5 sampled residents (#5) related to trazadone. The findings are: Review of Resident #5's current FL2 dated 04/26/19 revealed: -Diagnoses included vascular dementia, constipation, hypothyroidism, depressive disorder, hypertension and insomnia, -There was an order for trazadone (used to treat depression and insomnia) 12.5 mg at bedtime. Review of Resident #5's electronic Medication Administration Record (eMAR) for May 2019	D 367		

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revealed:
-There was an entry for trazadone 100 mg give one tablet at bedtime for insomnia.
-Trazadone was documented as administered from 05/01/19 to 05/22/19.
- There was an entry for trazadone 12.5 mg give one tablet as needed for pain at bedtime.
-Trazadone was not documented as administered from 05/01/19 to 05/22/19.

Observation of Resident #5's medications on hand on 05/24/19 at 10:30 am revealed:
-There was trazadone packaged by the pharmacy in bubble packages; a 50 mg tablet of trazadone had been quartered by the pharmacy and each quarter was packaged in separate bubbles for administering and there was no other trazadone for Resident #5.
-There were twenty six doses of 1/4 tablets of trazadone left in the bubble package.

Based on observations, interviews and record reviews it was determined Resident #5 was not interviewable.

Interview with the medication aide (MA) on 05/24/19 at 10:45 am revealed:
- She compared the medication in the bubble cards to the eMAR before she administered each medication.
-She did not realize she had documented on the eMAR for May 2019 that she had administered Resident #5 100 mg of trazadone; she did not "catch" the difference in dosages for Resident #5.
-She only administered one of the quarter tablets at a time to Resident #5.
-She did not realize there was another trazadone dosage on the eMAR.
-When there was a discrepancy between the eMAR and the medication she called the

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pharmacy for clarification and made the corrections on the eMAR herself.
-Resident #5 was a fairly new resident and the Registered Nurse (RN) had entered all of Resident #5's medication and information into the eMAR when Resident #5 was admitted.

Telephone interview with a second MA on 05/24/19 at 2:45 pm revealed:
-She double checked the medication, the dosage and the resident name on each medication card before administering to each resident.
-She administered medication to Resident #5; she could not remember if Resident #5 was ordered trazadone or the trazadone dosage.
-She had not seen any "red flags" on Resident #5's eMAR.

Interview with a third MA on 05/24/19 at 2:50 pm revealed:
-She looked at the medication label on the medication card and compared each medication to the eMAR.
-She compared the dosage to the eMAR; she had never noticed anything wrong with Resident #5's trazadone dosage.
-She had documented trazadone 100 mg as administered to Resident #5, but she was sure she had only given Resident #5 the 12.5 mg of trazadone because she only gave what was in the bubble.

Telephone interview with the pharmacist from the contracted pharmacy on 05/24/19 at 11:20 am revealed:
-The pharmacy had a physician's order for trazadone 12.5 mg at bedtime; the order was dated 01/24/19.
-Trazadone was dispensed on 04/17/19 for a 28 day supply; seven tablets were cut into quarters.

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-Trazadone was dispensed on 05/15/19 for a 28 day supply; seven tablets were cut into quarters.
-The pharmacy cut a 50 mg tablet into quarter to get the 12.5 mg dosage and packaged a quarter tablet into each bubble for administration.
-There was never an order for 100 mg of trazadone; only the trazadone 12.5 mg.
-The facility staff had the ability to enter information on the eMAR.

Telephone interview with a representative from the physician's office on 05/24/19 at 11:40 am revealed;
-There was an order for trazadone 12.5 mg take at bedtime; a 50 mg trazadone tablet should be cut into quarters and 1/4 of a tablet administered.
-She did not find an order for trazadone 100 mg.
-Resident #5 was ordered the trazadone 12.5 mg to help with insomnia.

Interview with the Administrator on 05/24/19 at 5:00 pm revealed:
-She did not think Resident #5's eMAR had been audited because she was admitted less than thirty days ago.
-She did not know trazadone 100 mg was documented as being administered every day to Resident #5.
-The MAs should have caught the dosage error and made corrections on the eMAR as well as let the RN know.
-The RN entered all new residents' information into the eMAR; sometimes "stuff" got deleted or accidentally entered wrong.

Interview with the RN on 05/24/19 at 5:45 pm revealed:
-She did not recall entering Resident #5's information on the eMAR; she did not know who entered the information.

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D 367	Continued From page 11 -MAs could enter new admission information on the eMAR. -She did not know the correct trazadone dosage for Resident #5; she did not know the MAs had documented administering trazadone 100 mg on the eMAR or that two entries for trazadone were on the eMAR. -She conducted quarterly reviews of the eMAR, but she had not conducted a review of Resident #5 because she was a new admission; Resident #5's eMAR would be reviewed in the next few days. -The MAs should be checking dosages when administering medications to all residents; one of the MAs should have caught the wrong dosage and order for the the trazadone. -No one had let her know of an issue with Resident #5's trazadone.	D 367		