STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049029	A. BUILDING: _____ B. WING _____	R 04/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHURCHILL	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 and the Iredell County Department of Social Services conducted an annual, follow-up survey, and complaint investigation on April 19-22, 2016 and April 25, 2016.	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 observation, record review and interviews, the facility failed to serve as ordered a texture modified diet to 2 of 2 residents (Residents #9 and #11). The findings are: A. Review of Resident #9's Resident Register revealed an admission date of 7/31/12. Review of Resident #9's current FL-2 dated 1/20/16 revealed: -Diagnoses included esophageal reflux and tooth decay. -No information in the diet order block. Review of Resident #9's current Personal Service Plan (assessment and care plan) dated 2/14/15 revealed: -A "carb[ohydrate] controlled diet." -"Reg[ular] portion."	D 310		

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D 310	Continued From page 1 -No assistance required for eating. Review of Resident #9's physician order for diet dated 9/11/15 revealed a mechanical soft/chopped diet. Review of Resident #9's Resident Log entries for 2016 to date revealed no entries related to her diet or the resident having difficulty chewing or swallowing. Observation of Resident #9 during lunch service on 4/19/16 at 12:35PM revealed: -She had a whole piece of Salisbury steak on her plate, covered with gravy. -The Salisbury steak was untouched. Interview with Resident #9 on 4/19/16 at 12:35PM revealed: -The amount of Salisbury steak served was "too much." -She had requested a grilled cheese sandwich which staff told her they would prepare for her. Review of the Modified Diet list, provided by the kitchen staff, revealed Resident #9 listed as having a texture modified/mechanical soft diet. Observation of Resident #9 during lunch service on 4/20/16 at 12:22PM revealed: -Whole pieces of bok choy on her plate which had not been touched. -Whole chicken nuggets covered in sesame seeds and a glaze. Interview with Resident #9 on 4/20/16 at 12:22PM revealed: -She had eaten one of the chicken nuggets. -She was not very hungry.	D 310		

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D 310	Continued From page 2 Review of the Daily Diet Modification Summary Report, provided by the kitchen, dated 4/20/16 revealed: -A column labeled "texture modified." -Under this column for the sesame chicken was the description "Omit sesame seeds. Grind and dispense with a 8 scoop. Serve with 103.2180 Poultry gravy or other gravy, 2 oz [ounce]." -Under this column for the Salisbury steak was the description "Grind and dispense with two 10 scoops. Serve with 103.087% Beef Gravy or other % gravy, 2 oz." -Under this column for the sautéed bok choy was the description "Omit and substitute with #40.1500 Sautéed Zucchini served as a 0.5 cup portion. Serve well cooked, tender." Refer to the interview with the Dietary Supervisor on 4/20/16 at 12:35PM. Refer to the interview with the Cook on 4/22/16 at 1:20PM. B. Review of Resident #11's Resident Register revealed an admission date of 11/20/06. Review of Resident #11's current FL-2 dated 5/22/15 revealed: -Diagnoses which included a history of squamous cell carcinoma of the mouth. -No diet indicated in the diet block. Review of Resident #11's current Personal Service Plan (assessment and care plan) dated 3/13/15 revealed: -The comments "has had problems with swallowing and would benefit from texture modified but refuses." -"Reg[ular] portion." -No assistance required for eating.	D 310		

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D 310	Continued From page 3 Review of Resident #11's physician order for diet dated 7/31/15 revealed: -A check in the block for a texture modified diet. -A texture modified diet description of "moist, soft-solid, meats and poultry ground and expected that mixed textures are tolerated on this diet." Review of Resident #11's Resident Log entries for 2016 to date revealed no entries related to her diet or as having difficulty chewing or swallowing. Observation of Resident #11 during lunch service on 4/20/16 at 12:20PM revealed: -One piece of cut breaded chicken left on her plate. -Whole pieces of bok choy on her plate which had not been touched. Interview with Resident #11 on 4/20/16 at 12:20PM revealed: -She had cut up her chicken. -She had eaten her chicken without any coughing or problems. -She could not eat her bok choy. A second interview with Resident #11 on 4/20/16 at 12:25PM revealed: -In her room she had soup and other food items she could eat. -She was not able to have dentures due to a part of her lower jaw was removed. Refer to the review of the Daily Diet Modification Summary Report, provided by the kitchen, dated 4/20/16. Refer to the interview with the Dietary Supervisor on 4/20/16 at 12:35PM.	D 310		

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D 310	Continued From page 4 Refer to the interview with the Cook on 4/22/16 at 1:20PM. _____ Interview with the Dietary Supervisor on 4/20/16 at 12:35PM revealed: -His observation of Resident #9's plate revealed it not to be a mechanical soft diet. -He expected residents to be served the diets as ordered and noted on the diet list. -The cook was responsible for following the menu to ensure that mechanical soft diets were served properly. Interview with the Cook on 4/22/16 at 1:20PM revealed: -The Medication Aides would tell the kitchen staff if a resident had an ordered diet. -The Dietary Supervisor updated the diet list "weekly or monthly." -On 4/20/16 there was a new cook training in the kitchen who had already plated the meals for the residents. -She did not have a chance to check behind the new cook before the meals were taken to the dining room to be served. -She expected kitchen staff to follow the diet list for ordered diets.	D 310		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the	D 366		

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D 366	Continued From page 5 medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to directly observe 1 of 1 residents (Resident #1) take 11 medications and supplements which resulted in a medication error (another resident (Resident #2) took them instead). The findings are: Review of Resident #1's Resident Register revealed: -No admission date. -The comment "forgetful, needs reminders." Review of Resident #1's current FL-2 dated 3/9/16 revealed: -Diagnoses included atrial fibrillation, depression, cerebrovascular accident and hyperlipidemia. -Physician orders for atorvastatin (a cholesterol lowering medication), 20mg one QD (everyday). -Physician orders for bupropion (an antidepressant), 150mg one QD. -Physician orders for escitalopram (an antidepressant), 20mg, one QD. -Physician orders for apixaban (an anticoagulant), 5mg, one BID (twice a day). -Physician orders for CoQ10 (a supplement for heart health), one QD. -Physician orders for glucosamine (a supplement for bone joint health) one OD. -Physician orders for vitamin D3, one QD. -Physician orders for vitamin B12.	D 366		

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D 366	Continued From page 6 Review of Resident #1's Resident Log revealed an admission date of 3/18/16. Review of Resident #1's physician orders dated 4/4/16 revealed: -Tumeric (a supplement), 400mg one QD. -Greensource (a supplement), one BID. -Apoaequorin (a supplement for memory) one QD. Review of Resident #1's physician orders dated 4/5/16 revealed the glucosamine dose to be 1500mg, one BID. Review of Resident #1's physician orders dated 4/7/16 revealed: -The dosage of the Vitamin D3 to be 5,000 IU, QD. -The dosage of the Vitamin B12 to be 5,000mcg, one QD. Review of Resident #1's Personal Service Plan (assessment and care plan), undated, revealed the resident as independent in all care and "sometimes forgetful." Review of Resident #1's Resident Log dated 4/11/16 revealed an entry at 1:00PM by Medication Aide, Staff A "make sure that resident takes his meds." Review of an incident report dated 4/12/16 and timed 9:00AM revealed: -The nature of the incident was "Medication, Family Administered, Wrong Drug, Wrong Resident, [Resident #1] gave his meds to [Resident #2]." -There was no apparent injury. -The emergency contact, nurse and physician were notified.	D 366		

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D 366	Continued From page 7 -Medication Aide, Staff A Review of Resident #1's Medication Administration Record (MAR) for 4/12/16 at 8:00AM and 9:00AM revealed medications were documented by staff, as ordered on his FL-2, dated 3/9/16 and as ordered or clarified by his physician on 4/4/16, 4/5/16 and 4/7/16. Review of the facility policy titled "Medication and Treatment- General Guidelines for Medication Administration/Assistance", revision date of October 2015, revealed: -"Residents should be observed taking the medication followed by the offering water or other fluids." -"Medications should not be left for the resident to consume at a later time." Review of Resident #2's Fax Physician Order Sheet dated 4/12/16 revealed: -The request was from Medication Aide, Staff A. -"[Resident #1] had given his meds to [Resident #2], levothyroxine 125mcg, [brand name for atorvastatin] 20mg, bupropion XL, [brand name for escitalopram], [brand name for Apixaban], COQ10, glucosamine, turmeric, Greensource, Vitamin B-12, [brand name for apoaequorin]." -A statement signed by the physician "as discussed on the phone, watch for evidence of bruising and bleeding." Review of a second Fax Physician Order Sheet for Resident #2 dated 4/12/16 revealed: -The request was from Medication Aide, Staff A. -"Can I get order to hold [Resident #2's] meds where [Resident #1] gave her his medications-please advise." -A statement signed by the physician "may hold this morning's medications."	D 366		

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D 366	Continued From page 8 Review of Resident #2's Resident Log from 4/12/16 at 1:00PM through 4/12/16 at 10:00PM revealed entries stating no bleeding or bruising. Review of Medication Aide, Staff A's, personal file revealed she had all required training to be a medication aide. Telephone interview with a family member of Resident #1 on 4/21/16 at 9:30AM revealed: -Medication Aide, Staff A, called on 4/12/16 to report that Resident #1 had given his medications to another resident. -It was reported the Medication Aide placed Resident #1's medications in front of him then left to get Resident #2's medications. -The Medication Aide returned to find that Resident #1 had given his medications to Resident #2. Interview with Medication Aide, Staff A, on 4/22/16 at 10:05AM revealed: -There were currently no residents in the facility assessed to be safe for self-administration of medications. -She gave Resident #1 his medication and he replied to her that he would take them. -She told Resident #1 she would get the medications for Resident #2. -The residents were seated in the dining room, the medication cart was just outside the dining room door and she had a line of sight with the residents. -She did not see Resident #1 give his medications to Resident #2. -When she went back into the dining room, Resident #1 reported he had given the medications left with him to Resident #2. -The Resident Care Coordinator, Health and	D 366		

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D 366	Continued From page 9 Wellness Director, family contact and the physician were notified. -The physician was only concerned about Resident #2 getting the apixaban. -She received counseling from her supervisor. -She thought the walkie-talkie she carried was a "distraction" to medication administration. -While passing medications that day, other residents in the dining room were "hollering" for something to drink. -She did not recall any directed in-service training following this event. Interview with the Health and Wellness Director on 4/25/16 at 1:40PM revealed: -She expected medication aides to supervise residents when taking medications. -She was aware of the incident involving Resident #1 and recalled counseling the medication aide involved.	D 366		
D 410	10A NCAC 13F .1010(c) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to have available a medication for 1 of 7 residents reviewed for medication administration (Resident #2).	D 410		

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D 410	Continued From page 10 The findings are: Review of Resident #2's current FL-2 dated 3/14/16 revealed: -Diagnoses which included glioblastoma, depression and memory impairment. -An order for methylphenidate (a central nervous system stimulant), 10mg, one twice a day. Review of Resident #1's Resident Register revealed no admission date. Review of Resident #2's Resident Log revealed an admission date of 3/18/16. Review of Resident #2's Medication Administration Record (MAR) for March 2016 revealed: -Transcription of the order for methylphenidate, 10mg, take one tablet by mouth twice a day. -Documentation by staff of administration of methylphenidate at prescribed times. Review of Resident #2's MAR for April 2016 revealed: -Circles around the initials for the administration times of 4/2/16 at 3:00PM, 4/3/16 at 8:00AM, 4/3/16 at 3:00PM, 4/4/16 at 8:00AM and 4/4/16 at 3:00PM. -In a box under the circled initials for 4/4/16 at 3:00PM was another set of initials. Review of a Resident Log entry for Resident #2 dated 4/4/16 at 2:00PM revealed the resident had run out of methylphenidate (referred to by a brand name) and a family member went to see the attending physician to get a new prescription. Observation of Resident #2's medications on	D 410		

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D 410	Continued From page 11	D 410		

hand on 4/25/16 at 2:15PM revealed:
-A pill bottle with a commercial pharmacy label printed with Resident #2's name and the name of the medication methylphenidate, 10mg tablets.
-A printed pharmacy fill date of 4/4/16.
-Numerous tablets.

Interview with Resident #2's family member on 4/21/16 at 9:30AM revealed:
-Upon admission the family was informed that if they did not use the contract pharmacy they would pay an additional fee for using a commercial pharmacy.
-On 4/3/16 a medication aide (name could not be recalled) asked if they had Resident #2's "narcotics."
-The facility had run out of Resident #2's "narcotic" for which a handwritten prescription was required from the physician.
-The physician was on vacation at the time but had been in the facility to see Resident #2 3 days prior.
-Another family member got the handwritten prescription from the physician's office on 4/4/16 and had it filled at a commercial pharmacy.

Interview with a Pharmacy Technician from the facility's contract pharmacy on 4/25/16 at 11:00AM revealed:
-The contract pharmacy received admission orders on 3/18/16 and they were entered into the computer on 3/19/16.
-The FL-2 was received showing the order for the methylphenidate but as this is a schedule II controlled medication, a handwritten prescription was required from the doctor.
-There was no record of the contract pharmacy ever receiving the handwritten prescription so the medication was never dispensed.

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D 410	Continued From page 12 Attempted telephone interview with Resident #2's attending physician on 4/25/16 at 12:55PM but was unsuccessful. Interview with the Health and Wellness Director on 4/25/16 at 1:40pm revealed: -Resident #2 had arrived to the facility on a weekend but had not seen her attending physician yet to receive a handwritten prescription for methylphenidate. -Circles around initials on the MAR indicated a medication was not given. -When a resident is down to the last seven days' worth of medication medication aides were expected to contact the physician for any handwritten prescriptions needed for refills. -She expected staff to contact her if there were problems with obtaining prescription refills. -As staff counted remaining pills during their controlled substance counts, they should have noted the few remaining pills. Interview with Medication Aide, Staff I, on 4/25/16 at 2:15PM revealed: -She knew Resident #2's methylphenidate was "running low" in early April 2016 but the attending physician was on vacation. -There were no replies to requests for a new handwritten prescription from the physician's office. -Resident #2 used her home supply of methylphenidate that she brought with on admission until they were gone. -A family member voiced concern about this and staff asked them to pursue getting a handwritten prescription, which they did and is the current supply being used by the resident. -Before the current supply runs out the facility will get a new handwritten prescription.	D 410		

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D 472	Continued From page 13	D 472		
D 472	10A NCAC 13F .1404 Special Care Unit Building Requirements 10A NCAC 13F .1404 Special Care Unit Building Requirements In addition to meeting all applicable building codes and licensure regulations for adult care homes, the special care unit shall meet the following building requirements: (1) Plans for new or renovated construction or conversion of existing building areas shall be submitted to the Construction Section of the Division of Facility Services for review and approval. No special care unit for residents with a mental health disability shall serve more than 12 residents. A facility shall have no more than one special care unit for residents with a mental health disability. (2) If the special care unit is a portion of a facility, it shall be separated from the rest of the building by closed doors. (3) Unit exit doors may be locked only if the locking devices meet the requirements outlined in the N.C. State Building Code for special locking devices. (4) Where exit doors are not locked, a system of security monitoring shall be provided. (5) The unit shall be located so that other residents, staff and visitors do not have to routinely pass through the unit to reach other areas of the building. (6) At a minimum the following service areas shall be provided within the special care unit: staff work area, nourishment station for the preparation and provision of snacks, and lockable space for medication storage. (7) Living and dining space shall be provided within the unit at a total rate of 30 square feet per	D 472		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049029	A. BUILDING: _____ B. WING _____	R 04/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHURCHILL	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

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resident and may be used as an activity area.
(8) Direct access to an outside area shall be provided.
(9) A toilet and hand lavatory shall be provided within the unit for every five residents.
(10)A tub and shower for residents' bathing shall be provided within the unit.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to assure Special Care Unit (SCU) residents had direct access to an outside area.

The findings are:

Observation of the SCU on 4/19/16 at 12:09pm revealed:
-It was located on the second floor of the building.
-The current census was 16.
-There were 15 residents in the Special Care Unit.
-One resident was out of the facility with family.
-A room at the end of the hall on the right, with an entry door that was locked with a keypad, which contained the elevator that led to the first floor SCU courtyard.

Confidential interview with one staff member revealed:
-The SCU residents had never used the secured courtyard that was available.
-"We are not allowed to use it."
-"We were told by the Fire Marshal that we can't go out the door to use the elevator because there is no keypad."
-The elevator went down to the first floor where the SCU courtyard was located.

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D 472	Continued From page 15 -The courtyard was secured by a fence and a door that was locked with a key. -Staff did not know the code to the keypad that led to the elevator room and did not have a key for the locking fence door. Confidential interview with a second staff member revealed: -The only time residents leave the unit is to go out of the building with family or to doctor visits. -Staff did not know the code for the keypad that led to the elevator room. Confidential interview with a third staff member revealed: -"They don't go outside." -"We were told by [former staff name] that we can't take them [the residents] out due to no keypad for the elevator per the local fire department." -Staff had never taken any residents to the SCU secured courtyard. -Staff did not know the code for the keypad that led to the elevator room. Confidential interview with a fourth staff member revealed this staff member did not have the code for the keypad that led to the elevator room. Confidential interview with a family member revealed: -The family member had visited the SCU for over a year, on a daily basis, and sometimes twice daily. -The SCU courtyard was "not open." -The family member stated "I've been fighting this a long time" and was told the facility was "working on it." -The family member had volunteered in the past to help with the outdoor area and to do activities	D 472		

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with the residents in the courtyard.
-"I think the problem is not enough staff to take them [the residents] down to the area, they have only had 2 staff working on the floor."
-The family member had voiced her concerns to the former Administrator and to the former Activities Coordinator on the SCU.

Confidential interview with a second family member revealed:
-The family had visited the SCU at least once a week for the past month.
-"I don't know if staff takes her outside, but we take her out sometimes."

Interview with the Administrator on 4/25/16 at 12:00pm revealed:
-The SCU had an outdoor courtyard for the residents.
-The residents were not allowed to use the area per the Fire Marshal.
-He was unsure of the reason why they could not use the area and was going to contact the Fire Marshal.
-He was unaware that staff did not have the code for the keypad that led to the SCU elevator room.

Telephone interviews with the local Assistant Fire Marshal on 4/25/16 at 1:10pm and 1:35pm revealed:
-She did not know why the residents and staff could not use the secure courtyard or the elevator in the SCU and would ask her supervisor.
-Per her supervisor [the Fire Marshal] the only time that residents or staff could not use the elevator was during a fire.
-All staff should have the code to the keypad that opens the door to the elevator room.
-The Maintenance Director was responsible for assuring that staff had the code.

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D 472	Continued From page 17 Telephone interview with the Maintenance Director on 4/25/16 at 1:39pm revealed he was never told that SCU staff could not use the elevators to take residents to the SCU courtyard.	D 472		