STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060060	A. BUILDING: _____ B. WING _____	07/31/2019

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BROOKDALE CHARLOTTE EAST	6053 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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 July 30, 2019 and July 31, 2019.	D 000		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the facility was maintained without chronic odors of urine. Observation on 07/30/19 at 9:30am of resident room #1222 revealed: -The room had a strong urine odor coming from the room into the hall on the second floor. -There was a urinal full of dark colored urine sitting on the floor beside one of the resident's wheelchair. -There was trash in two different trash cans overflowing onto the floor. -There was dirty laundry overflowing a laundry basket in the middle of the room. Attempted interview with the resident that resided in room #1222 on 07/30/19 at 9:30am was unsuccessful. Observation on 07/30/19 at 10:11am of resident room #1222 revealed:	D 075		

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D 075	Continued From page 1 -The room had a strong urine odor coming from the room into the hall on the second floor. -There was a urinal full of dark colored urine sitting on the table beside one of the resident's bed. -One of the resident's beds was unmade without linens on it. -Soiled linens remained in an overflowing laundry basket in the middle of the room. Observation on 07/30/19 at 1:30pm of resident room #1222 revealed: -The room had a strong urine odor coming from the room into the hall on the second floor. -There was an empty urinal on the floor beside one of the resident's beds. -There was a dark brown stain with a gray colored outline under the front of a resident's recliner on the laminate flooring. Interview with a personal care aide (PCA) on 07/30/19 at 1:35pm revealed: -Two male residents resided in room #1222. -Both male residents used urinals and required assistance at times emptying them in the bathroom toilet. -Urine had spilled onto the laminate flooring and one resident's bed at times. -She had cleaned up the spills on the floor with a designated disinfectant spray and wiped it up. -She had cleaned up the urine that had spilled on the floor, but the urine odor remained in the room. -She was going to make the housekeeper aware of the urine odor to have her mop the floor. -The resident's linens had been removed and placed in the laundry basket this morning. -Clean linens were going to be put on the resident's bed after they had been washed. -She did not know if the resident's clothes in the laundry basket were soiled or not.	D 075		

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D 075	Continued From page 2 -She was responsible for assisting the residents in room #1222 with toileting, bathing, changing their linens, and emptying the trash. Interview with the Resident Care Director (RCD) On 07/30/19 at 2:45pm revealed: -She was aware room #1222 had a strong urine odor. -She was going to have the housekeeper clean and mop the floor. Interview with a resident who resided in room #1222 and his visitor on 07/31/19 at 3:00pm revealed: -The resident and his visitor were not in his room currently because the urine odor was bothersome. -The resident's visitor had attempted to clean the resident's room to rid it of the urine odor. -The resident's visitor had spoken to the housekeeper on two different occasions to ask her to mop the resident's floor. -After all their efforts they had decided not to visit in the resident's room. Observation on 07/31/19 at 9:35am of resident room #1222 revealed: -The room had a strong urine odor coming from the room into the hall on the second floor. -There was an empty urinal on the floor beside one of the resident's bed. -There was a dark brown stain with a gray colored outline under the front of a resident's recliner on the laminate flooring. -The air coming from the air conditioning unit had a strong urine odor. -Dirty laundry remained in the laundry basket in the middle of the room. -Waste paper with dark yellow stains remained in the trash can in the bathroom.	D 075		

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D 075	Continued From page 3 Interview with the housekeeper on 07/31/19 at 9:35am revealed: -She was the only housekeeper working at the facility. -She had cleaned each room weekly. -She had swept, mopped, empty trash, cleaned the bathroom, and shower in resident room #1222 six days ago. -She had noticed the urine odor that remained in the room after cleaning it with enzyme cleansing bacterial soap. -She had not reported the lingering urine odor to anyone. Interview with the Regional Health and Wellness Nurse on 07/31/19 at 11:00am during a tour of resident room #1222 revealed: -She noticed the strong urine order in the room. -She saw the soiled clothes in the laundry basket in the middle of the room. -She saw the waste paper with dark yellow stains in the trash can in the bathroom. -The air conditioning unit was circulating air that smelled of strong urine. -She stated, "the resident must have spilled urine into the air conditioning unit." -The laminate flooring in the room was spongey feeling, and it had absorbed urine and might need to be replaced. Interview with the Administrator on 07/31/19 at 12:00pm revealed: -She had been told this morning about the condition of resident room #1222 this morning. -There was one housekeeper who had cleaned each resident's room once a week. -She expected the staff to report housekeeping issues. -She had addressed housekeeping issues that	D 075		

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D 075	Continued From page 4 had been brought to her attention. -She had not toured the resident's room on a routine basis.	D 075		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 2 sampled Medication Aides (Staff A and B) who administered insulin to residents completed training on the care of	D 164		

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diabetic residents prior to the administration of insulin.

1. Review of Staff A's personnel record revealed:
-Staff A was hired as a Medication Aide (MA) on 11/09/15.
-There was no documentation that Staff A had received training on the care of a diabetic resident.

Review of an electronic Medication Administration Record (eMAR) for July 2019 revealed Staff A had documented she had administered insulin to a resident on July 1, 9, 11, 15, 16, 17, 18, 22, 23, 25, 29 and 30 at 8:00pm.

Attempted telephone interview with Staff A on 07/31/19 at 11:02am was unsuccessful.

Refer to the interview with the Business Office Manager (BOM) on 07/31/19 at 10:54am.

Refer to the interview with the Administrator on 07/31/19 at 11:00am.

Refer to the interview with the Resident Care Coordinator on 07/31/19 at 11:08am.

Refer to the interview with the Corporate Nurse on 07/31/19 at 11:30am.

2. Review of Staff B's personnel record revealed:
-Staff B was hired as a Medication Aide (MA) on 07/24/18.
-There was no documentation that Staff B had received training on the care of a diabetic resident.

Review of an electronic Medication Administration Record (eMAR) for July 2019 revealed Staff B

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D 164	Continued From page 6 had documented she had administered insulin to a resident on July 6, 9, 15, 21, 23, 24, 29, and 30 at 8:00pm. Attempted telephone interview with Staff B on 07/31/19 at 11:03am was unsuccessful. Refer to the interview with the Business Office Manager (BOM) on 07/31/19 at 10:54am. Refer to the interview with the Administrator on 07/31/19 at 11:00am. Refer to the interview with the Resident Care Coordinator on 07/31/19 at 11:08am. Refer to the interview with the Corporate Nurse on 07/31/19 at 11:30am. Interview with the Business Office Manager (BOM) on 07/31/19 at 10:54am revealed: -The Health and Wellness Director was responsible for scheduling the diabetic training. -The BOM audited the personnel records and would send the Administrator a report of missing documents. -She did not know why Staff A and B had not received the diabetic training. Interview with the Administrator on 07/31/19 at 11:00am revealed: -The Health and Wellness Director was responsible for notifying the Corporate Nurse of newly hired Medication Aides (MA) that required the diabetic training. -The Corporate Nurse was responsible for ensuring the Medications Aides (MAs) received the diabetic training. -The Business Office Manager was responsible for auditing personnel files.	D 164		

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D 164	Continued From page 7 -She did not know why Staff A and Staff B had not received the diabetic training. Interview with the Resident Care Coordinator on 07/31/19 at 11:08am revealed she did not know what the process was to ensure the MAs received the diabetic training. Interview with the Corporate Nurse on 07/31/19 at 11:30am revealed: -She was responsible for ensuring the MAs received the diabetic training. -The Health and Wellness Director would notify her of newly hired MAs that required the diabetic training. -She did not know why the MAs had not received the training.	D 164		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by:	D 276		

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D 276	Continued From page 8 TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure implementation of treatment orders for 1 of 5 sampled resident (#2) related to oxygen. The findings are: Review of Resident #2's current FL2 dated 05/30/19 revealed diagnoses included acute encephalopathy, right parietal bone metastatic lesion without intracranial extension, metastatic extraskelatal myxoid chondrosarcoma, diabetes, atrial fibrillation, and acute kidney injury. Review of Resident #2's Physician Orders revealed: -There was an order dated 07/05/19 for oxygen 2L via nasal canula every night for hypoxia (the absence of enough oxygen in the tissues to sustain body functions). -There was an order dated 07/05/19 for oxygen 2L via nasal canula as needed during the day for shortness of breath, confusion, or weakness. Review of Resident #2's Physician Visit Note dated 07/05/19 revealed: -"He presented today for ongoing management of chronic obstructive pulmonary disease." -"Oxygen 85% on room air at rest today, needing supplemental oxygen." -"Review of respiratory system: the patient complained of shortness of breath upon exertion but denied cough, wheezing, and chest congestion." -"Hypoxemia discussion oxygen 2L via nasal canula as needed ordered." Review of "Pulse Oximetry-Oxygen Saturation	D 276		

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Intermittent Monitoring" Policy effective March 2014 revealed:
-"Intermittent pulse oximetry testing may not be performed by a community employed licensed nurse or other associates unless licensed nurses are present and assigned to an assisted living community on a 24 hour per day/7 days per week basis to interpret/respond to pulse oximetry results."
-"The resident must be currently receiving oxygen with equipment available, and where permitted per AL state regulation."
-"A community owned pulse oximeter may only be made available in the community on a consistent basis when the licensed nurse staffing and regulatory requirement noted in the policy overview above is met."

Interview with Resident #2 and his visitor on 07/30/19 at 3:00pm revealed:
-He had become short of breath at times.
-He was weak and sleepy at times.
-His physician had ordered oxygen for him, but there had been a problem with getting his insurance to approve it.
-The oxygen had been ordered a few weeks ago.
-The Health and Wellness Director (HWD) was supposed to take care of getting his oxygen.

Interview with a medication aide (MA) on 07/30/19 at 2:30pm revealed:
-She had not seen an order for oxygen for Resident #2.
-The HWD processed all physicians' orders.
-She had never seen Resident #2 wearing oxygen.
-It was against the facility's policy for staff to check resident's oxygen level with a pulse oximeter.

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D 276	Continued From page 10 Interview with the HWD on 07/30/19 at 2:45pm revealed: -She had seen Resident #2's physician order for oxygen on 07/05/19. -She had contacted the physician's office to follow up, but she could not recall the date. -The order required approval from the resident's insurance company. -She did not have documentation of follow up with the physician's office. -She had not set a reminder for herself to continue to follow up. -It was against the facility's policy for her to check resident's oxygen level with a pulse oximeter. Interview with Resident #2's Nurse Practitioner on 07/30/19 at 4:10pm revealed: -She saw the resident on 07/05/19 and ordered oxygen. -Resident #2 complained of shortness of breath, weakness, and fatigue. -She ordered the oxygen because she felt he could benefit from having it available. -She ordered oxygen at night because she felt he was experiencing hypoxemia. -If the resident continued to experience hypoxemia, he could become more compromised without oxygen. -No one from the facility had contacted her until today to follow up on the order. -She expected the HWD from the facility would have continued to remind her office if there was a problem getting the oxygen. -The HWD contacted her today to get an order to hold the oxygen until the insurance can approve it. Interview with the Administrator on 07/31/19 at 12:00pm revealed: -She did not know Resident #2's oxygen order	D 276		

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D 276	Continued From page 11 had not been implemented. -She expected the HWD to follow up on all physicians' orders. -The HWD had not made her aware of any problems with Resident #2's oxygen until yesterday. -It was against the facility's policy for staff to check oxygen level with a pulse oximeter. -If an assessment for insurance approval of oxygen was needed the HWD should communicate it with the physician. -They had failed to follow up on the oxygen order. _____ The facility failed to implement a physician's order for oxygen for Resident #2. The facility's failure placed Resident #2 at increased risk for hypoxia, shortness of breath, confusion, and weakness which was detrimental to the health and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/31/19 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED October 2, 2019.	D 276		
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	D 358		

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D 358	Continued From page 12 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 for 1 of 5 sampled residents related to administering medications used to treat constipation and diabetes (Resident #4). The findings are: Review of Resident #4's current FL2 dated 04/15/19 revealed: -Diagnoses included diabetes, hypertension, nephropathy, congestive heart failure, and atrial fibrillation. -There was a physician's order for Movantik 25mg take 1 tablet by mouth daily (used to treat constipation). -There was a physician's order for Basaglar Kwikpen 100units/ml inject 25units daily (used to treat diabetes). a. Review of Resident #4's June 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Movantik 25mg take 1 tablet daily for scheduled	D 358		

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to be administered at 8:00am.
-Movantik was documented as administered at 8:00am for 9 of 30 opportunities from 06/01/19 to 06/30/19.
-Movantik was documented as "not available; waiting on prior authorization" for 20 opportunities during the month of June.

Review of Resident #4's July 2019 eMAR revealed:
-There was a computer-generated entry for Movantik 25mg take 1 tablet daily scheduled to be administered at 8:00am from 07/01/19 to 07/10/19 and at 9:00am from 07/11/19 to 07/30/19.
-Movantik was documented as administered at 8:00am for 2 of 10 opportunities from 07/01/19 to 07/10/19 and documented as administered at 9:00am for 7 of 20 opportunities from 07/11/19 to 07/30/19.
-Movantik was documented as "not available; waiting on prior authorization" for 22 opportunities during the month of June.

Observation of medication on hand for Resident #4 on 07/30/19 at 2:58pm revealed there was no Movantik 25mg available to administer to Resident #4.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/31/19 at 11:25am revealed:
-The pharmacy never dispensed Movantik 25mg to Resident #4.
-Resident #4's insurance did not cover Movantik and the pharmacy was waiting on approval.
-The pharmacy had faxed the facility notification of the problem on 05/06/19 and 05/15/19.

Interview with a medication aide (MA) on

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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 358	Continued From page 14	D 358		

07/31/19 at 10:58am revealed:
-She knew the Movanitk was not available to administer to Resident #4.
-The MA's were responsible for making sure each resident had all medications available for administration.
-The Health and Wellness Director (HWD) or the Resident Care Coordinator (RCC) was responsible for working through any problems preventing a medication from being available for administration to the residents.
-She told the HWD and RCC that Resident #4 did not have Movantik available to administer.

Interview with the RCC on 07/30/19 at 12:59pm revealed:
-She knew Resident #4 did not have Movantik available to be administered.
-She knew the HWD had faxed Resident #4's primary care provider to let her know.

Interview with the HWD on 07/30/19 at 4:30pm revealed:
-She knew Resident #4 did not have Movantik available in the medication cart.
-She knew the Movantik required insurance approval.
-She had faxed Resident #4's primary care physician on 06/18/19 regarding the insurance approval but had not received a response.
-She had not contacted Resident #4's primary care physician since 06/18/19.

Telephone interview with a nurse from Resident #4's primary care physician's office on 07/30/19 at 4:10pm revealed:
-She did not know Resident #4 was not receiving Movantik has ordered by the physician.
-Movantik was listed on Resident #4's current medication list and she should be administered

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	HAL060060	A. BUILDING: _____ B. WING _____	07/31/2019

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D 358	Continued From page 15 the medication. Interview with the Administrator on 07/31/19 at 9:20am revealed: -She did not know the Movantik for Resident #4 was not available for administration. -She did not know the pharmacy had contacted the facility related to an insurance rejection that prevented the medication to be dispensed to Resident #4. -The HWD or her designee (RCC) was responsible for processing all medication orders and making sure medications were available for the residents. b. Review of Resident #4's physician's orders dated 05/23/19 revealed a physician's order for Basaglar Kwikpen 100units/ml inject 20units daily (Kwikpen was a device used to administer medication). Review of Resident #4's June and July 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Basaglar Kwikpen 100units/ml inject 20units once daily for diabetes; unsupervised self-administration scheduled to administration at 8:00pm. -It was documented from 06/01/19 to 07/30/19 that Basaglar Kwikpen was self-administered by the resident. Observation of medication on hand for Resident #4 on 07/30/19 at 2:58pm revealed: -Resident #4 kept her insulin in the nightstand beside her bed. -Basaglar Kwikpen was not available to administer to Resident #4.	D 358		

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D 358	Continued From page 16 Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/31/19 at 11:25am revealed the pharmacy had not dispensed Basaglar Kwikpen to Resident #4. Interview with Resident #4 on 07/30/19 at 3:05pm revealed: -She had used multiple insulins in the past for her diabetes. -She had not received Basaglar Kwikpen since she was admitted to the facility. Interview with the medication aide (MA) on 07/30/19 at 3:12pm revealed: -Resident #4 kept her insulin in her room and administered it to herself. -She did not know what type of insulin she was prescribed. -She did not check to make sure Resident #4 had the correct insulin available to be administered. Telephone interview with a nurse from Resident #4's primary care physician's office on 07/30/19 at 4:10pm revealed Resident #4 was supposed to be administered Basaglar Kwikpen. Interview with the Resident Care Coordinator (RCC) on 07/31/19 at 8:45am revealed: -She did know Resident #4 had a physician's order for Basaglar Kwikpen. -She had administered medications to Resident #4 several weeks ago and Resident #4 had 1 pen of Basaglar Kwikpen in her room for self-administration. -She did not know why it was currently not available for Resident #4. -The Basaglar Kwikpen "must have been filled by the back up pharmacy." -The facility had multiple back up pharmacies and she did not know which pharmacy filled the	D 358		

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D 358	Continued From page 17 medication. Interview with the Administrator on 07/31/19 at 9:20am revealed: -She did not know the Basaglar Kwikpen for Resident #4 was not available for administration. -The Health and Wellness Director (HWD) or her designee (RCC) was responsible for processing all medication orders and making sure medications were available for the residents. -The HWD was responsible for faxing the medication orders to the pharmacy and approving new orders for the eMAR. c. Observation of medication on hand for Resident #4 on 07/30/19 at 2:58pm revealed: -Resident #4 kept her insulin in the nightstand beside her bed. -Resident #4 had 1 partially used pen of Lantus (used to treat diabetes) in her nightstand. -There were 2 unused Lantus pens available to be administered to Resident #4 located in the facility's refrigerator for overflow medications. -The Lantus was filled on 04/18/19 at a pharmacy not contracted with the facility. Interview with Resident #4 on 07/30/19 at 3:05pm revealed: -She had used multiple insulins in the past for her diabetes. -She had used Lantus since she was admitted to the facility. -She had brought Lantus with her to the facility. Review of Resident #4's June and July 2019 electronic Medication Administration Record (eMAR) revealed there was no computer-generated order for Lantus. Review of Resident #4's record revealed no	D 358		

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D 358	Continued From page 18 physician's order for Lantus. Interview with the medication aide (MA) on 07/30/19 at 3:12pm revealed: -Resident #4 kept her insulin in her room and administered it to herself. -She did not know what type of insulin she was prescribed. -She did not check to make sure Resident #4 had the correct insulin available to be administered. Telephone interview with a nurse from Resident #4's primary care physician's office on 07/30/19 at 4:10pm revealed Resident #4 did not have a current medication order for Lanus. Interview with the Resident Care Coordinator (RCC) on 07/31/19 at 8:45am revealed: -She knew Resident #4 self-administered her own insulin. -She did know Resident #4 was using Lantus but did not have an order for the medication. -She had administered medications to Resident #4 a few weeks ago and Resident #4 had the correct insulin available for administration. Interview with the Administrator on 07/31/19 at 9:20am revealed: -She did not know Resident #4 was self-administering Lantus without a physician's order. -The Health and Wellness Director (HWD) or her designee (RCC) was responsible for processing all medication orders and making sure medications were available for the residents. -The HWD was responsible for faxing the medication orders to the pharmacy and approving new orders for the eMAR.	D 358		

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D912	Continued From page 19	D912		
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: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to assure implementation of a physician orders for oxygen. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure implementation of physician orders for 1 of 5 sampled residents (Resident #2) for physician orders for oxygen 2L via nasal canula every night for hypoxia (an absence of enough oxygen in the tissues to sustain body functions), and oxygen 2 L via nasal canula as needed during the day for shortness of breath, confusion, or weakness. [Refer to Tag D276 10A NCAC 13F .902(c)(3-4) Health Care (Type B Violation)]. CORRECTION DATE FOR THE TYPE B VIOLATIONS SHALL NOT EXCEED OCTOBER 2, 2019.	D912		

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