| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL090007 | A. BUILDING: _____ B. WING _____ | 10/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE UNION PARK | 1316 PATTERSON AVENUE MONROE, NC 28112 |

| (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<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on October 27, 2021 with an exit date of October 28, 2021. | D 000 | | |
| D 280 | 10A NCAC 13F .0903(c) Licensed Health Professional Support<br><br>10A NCAC 13F .0903 Licensed Health Professional Support<br>(c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:<br>(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;<br>(2) evaluating the resident's progress to care being provided;<br>(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and<br>(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews the facility failed to ensure a Licensed Health Professional Support (LHPS) assessment | D 280 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL090007 | A. BUILDING: _____ B. WING _____ | 10/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| D 280 | Continued From page 1 | D 280 | | |

was completed quarterly for 2 of 5 sampled residents (#1 and #5) with LHPS tasks of applying and removing thromboembolic (TED) hose (#1) and finger stick blood sugars (#5).

The findings are:

1. Review of Resident #1's current FL2 dated 01/17/21 revealed diagnoses included chronic heart failure (CHF), atrial fibrillation, hypertension and hyperlipidemia.

Review of Resident #1's subsequent physician's order dated 05/05/21 revealed an order for compression stockings to be applied in the morning and removed in the evening.

Review of Resident #1's LHPS evaluation dated 01/17/21 revealed the Licensed Health Professional Support (LHPS) did not identify any tasks, including the application and removal of TED hose.

Review of Resident #1's record revealed there was no documentation of an LHPS evaluation completed since 01/17/21.

Observation on 10/28/21 at 1:15pm revealed:
-Resident #1 was lying in his bed sleeping.
-His ankles to mid shin were exposed and he did not have TED hose on.
-There was a pair of TED hose hanging on the grab bar in the resident's bathroom.

Interview with a medication aide (MA) on 10/28/21 at 1:22pm revealed:
-Resident #1 had an order for TED hose to be applied in the morning and removed in the evening.
-Third shift staff were to put the TED hose on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL090007 | A. BUILDING: _____ B. WING _____ | 10/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE UNION PARK | 1316 PATTERSON AVENUE MONROE, NC 28112 |

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|---|---|---|---|---|
| D 280 | Continued From page 2 | D 280 | | |

when he was getting dressed.
-The first shift staff usually checked the TED hose through out the day since he frequently liked to remove them.
-She had not checked today because he left the facility this morning during her medication pass.
-The resident was deaf and did not speak. The staff communicated with the resident by writing notes.

Interview with the previous Health and Wellness Registered nurse (HWD RN) on 10/28/21 at 12:30pm revealed she did not remember seeing an order for TED hose for Resident #1.

Attempted telephone interview with Resident #1's primary care physician (PCP) on 10/28/21 at 1:00pm was unsuccessful.

Attempted interview with Resident #1 on 10/28/21 at 2:10pm was unsuccessful.

Refer to interview with the previous Health and Wellness Director (HWD) on 10/28/21 at 12:30pm.

Refer to interview with the acting Administrator on 10/28/21 at 10/28/21 at 1:25pm.

2. Review of Resident #5's current FL2 dated 08/25/21 revealed:
-Diagnoses included chest pain, ischemic cardiomyopathy, chronic systolic heart failure, type 2 diabetes and hypertension.
-There was an order to check finger stick blood sugar (FSBS) every day.

Review of Resident #5's LHPS evaluation dated 04/27/21 revealed;
-The Licensed Health Professional Support

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL090007 | A. BUILDING: _____ B. WING _____ | 10/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE UNION PARK | 1316 PATTERSON AVENUE MONROE, NC 28112 |

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|---|---|---|---|---|
| D 280 | Continued From page 3<br>(LHPS) identified tasks of medication through injection, and physical and occupational therapy.<br>-There was no task identified for collecting and testing FSBS.<br><br>Observation during the medication pass on 10/27/21 at 8:49am revealed the medication aide (MA) checked Resident #5's FSBS.<br><br>Interview with the previous Health and Wellness Director (HWD) on 10/28/21 at 12:30pm revealed she did not review the orders that were entered by the pharmacy or other staff which included the FSBS for Resident #5.<br><br>Interview with a MA on 10/27/21 at 8:49am revealed Resident #5 was administered FSBS every morning.<br><br>Interview with Resident #5 on 10/27/21 at 8:50am revealed the MA's checked his FSBS every morning.<br><br>Refer to interview with the previous Health and Wellness Director (HWD) on 10/28/21 at 12:30pm.<br><br>Refer to the interview with the acting Administrator on 10/28/21 at 1:25pm.<br>_____<br>Interview with the previous Health and Wellness Registered nurse (HWD RN) on 10/28/21 at 12:30pm revealed:<br>-She was responsible for the completion of the residents' LHPS assessments until 07/01/21.<br>-She relied on the home health staff, the medication aides and the orders she processed to track which residents had an LHPS task.<br>-She did not review the orders that were entered by the pharmacy or other staff. | D 280 | | |

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|---|---|---|---|
| | HAL090007 | A. BUILDING: _____ B. WING _____ | 10/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE UNION PARK | 1316 PATTERSON AVENUE MONROE, NC 28112 |

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|---|---|---|---|---|
| D 280 | Continued From page 4<br><br>Interview with the acting Administrator on 10/28/21 at 1:25pm revealed:<br>-The LHPS assessments were to be completed every 90 days if the residents received a task, and yearly if the resident did not have a task.<br>-The LHPS assessment was to be completed within 30 days after a resident received a new task.<br>-The LHPS assessments were completed by the pharmacy and the previous HWD until June 2021.<br>-After June 2021 the LHPS assessments were not completed because the new HWD was not a nurse.<br>-The previous HWD was to assist with the LHPS assessments after June 2021 but did not get not get to the assessments due to new duties.<br>-She expected the LHPS assessments to be completed within the time frame as stated above. | D 280 | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.<br><br>This Rule is not met as evidenced by:<br>Based on interviews, observations and record reviews the facility failed to ensure therapeutic diets were served as ordered for 1 of 4 sampled | D 310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL090007 | A. BUILDING: _____ B. WING _____ | 10/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE UNION PARK | 1316 PATTERSON AVENUE MONROE, NC 28112 |

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|---|---|---|---|---|
| D 310 | Continued From page 5 | D 310 | | |

residents (Resident #5) with a diet order for a no added salt (NAS) diet.

The findings are:

Review of Resident #5's current FL2 dated 08/25/21 revealed:
-Diagnoses included high blood pressure, congestive heart failure, type 2 diabetes, history of a heart attack and history of a stroke.
-The diet section was blank.

Review of Diet Order Sheet dated 10/06/21 revealed an order for a NAS diet.

Review of therapeutic diet list posted in the kitchen revealed:
-The list was dated 02/18/21.
-Resident #5 was on a regular diet.

Observation of Resident #5 on 10/27/21 at 8:49am revealed he was eating potato chips and drinking a dark cola when the medication aide (MA) entered the room to give morning medications.

Interview with Resident #5 on 10/27/21 at 8:45am revealed:
-Potato chips and dark sodas were his favorite snacks.
-He usually consumed 2-3 cans of dark soda per day and 1, 5.5 oz can of potato chips in 2-3 days.

Interview with the Dietary Manager (DM) on 10/27/21 at 11:00am revealed:
-The kitchen had a Daily Diet Modification Summary Report that was referenced when a resident was ordered a therapeutic diet.
-The kitchen followed the 2 gram sodium diet menus for residents on a NAS diet.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL090007 | A. BUILDING: _____ B. WING _____ | 10/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE UNION PARK | 1316 PATTERSON AVENUE MONROE, NC 28112 |

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|---|---|---|---|---|
| D 310 | Continued From page 6<br><br>Review of the Daily Diet Modification Summary Report for 10/27/21 revealed the planned meal for the 2 gram sodium lunch service was a low sodium Greek salad, rosemary pork loin, low sodium roasted red skin potatoes, steamed cabbage and a whole grain roll with low sodium margarine.<br><br>Observation of the lunch meal service on 10/27/21 at 12:15pm revealed Resident #5 was served a Philly cheesesteak sandwich with a side of French fries.<br><br>Interview with Resident #5 on 10/28/21 at 12:30pm revealed:<br>-The facility had not restricted what he can eat at mealtimes.<br>-He liked to order a Philly cheesesteak or bacon, lettuce and tomato sandwich instead of the preplanned meal.<br>-He typically ordered a side of French fries, potato chips, coleslaw or potato salad with his sandwiches.<br><br>Interview with the DM on 10/28/21 at 1:30pm revealed:<br>-The RCC was responsible to giving the kitchen new diet orders.<br>-He was responsible for updating the therapeutic diet list in the kitchen.<br>-The therapeutic diet list was normally updated weekly.<br>-He updated the current therapeutic diet list on 10/25/21 but forgot to change the date at the top of the page.<br>-He knew that Resident #5 was on a NAS diet but forgot to update his diet order on the therapeutic diet list.<br>-Resident #5 consistently requested food that | D 310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL090007 | A. BUILDING: _____ B. WING _____ | 10/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE UNION PARK | 1316 PATTERSON AVENUE MONROE, NC 28112 |

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|---|---|---|---|---|
| D 310 | Continued From page 7 | D 310 | | |

was not allowed on a NAS diet and refused to eat the preplanned meal for the NAS diet.
-The DM educated Resident #5 about high sodium food every time he asked for something that was not allowed on his diet.
-After the education, Resident #5 continued to request the food so the DM prepared it for him.
-He informed the RCC that Resident #5 had been ordering food not allowed on a NAS diet.

Interview with the Resident Care Coordinator on 10/28/21 at 1:50pm revealed:
-If a resident requested food not allowed on their diet then they should be educated.
-If they continued to request the food after education then it should be provided.
-Dietary staff were responsible for alerting clinical staff residents food refusals so they could be documented.
-She was not aware that Resident #5 had been requesting food not allowed on his diet.

Interview with Resident #5 on 10/28/21 at 2:07pm revealed:
-The DM told him after lunch that he was on a NAS diet and he needed to limit his intake of high sodium foods.
-Today was the first day that the DM told him he was on a NAS diet.

Interview with the Administrator on 10/28/21 at 2:00pm revealed:
-The DM was responsible for maintaining an updated therapeutic diet list.
-She expected a physician's diet order to be followed by the kitchen.
-If the resident refused their therapeutic diet the clinical staff needed to be aware.

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|---|---|---|---|
| | HAL090007 | A. BUILDING: _____ B. WING _____ | 10/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BROOKDALE UNION PARK | 1316 PATTERSON AVENUE MONROE, NC 28112 |

| (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 338 | Continued From page 8 | D 338 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights | D 338 | | |

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure resident rights were maintained as related to the freedom to participate in the communal dining room for meals after the facility had been out of outbreak status for 5 days, and were still receiving their meals in their room in styrofoam containers and plastic silverware.

The findings are:

Interviews with 4 residents on the tour of the facility on 10/27/21 from 8:30am to 10:15am revealed:
-A resident reported eating all of his meals in his room for about 2 months due to COVID cases in the facility, and he felt as if has going "stir crazy".
-He was allowed to go out of the facility with his family recently which made him very happy to see other people.
-A second resident was new to the facility and was sad that she had not been able to meet many residents due to eating all of her meals in her room.
-A third resident exclaimed that she was very social and liked checking on the residents to see how they were doing.
-She felt very sad and worried that some of the residents may have declined or were deceased during this time.
-She tried to keep busy, but it was hard on her not

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|---|---|---|---|
| | HAL090007 | A. BUILDING: _____ B. WING _____ | 10/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE UNION PARK | 1316 PATTERSON AVENUE MONROE, NC 28112 |

| (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 338 | Continued From page 9 | D 338 | | |

to see the other residents at meals.
-A fourth resident was tired of watching TV and wanted to see other residents at meals.
-A fifth resident was bored and wanted to be able to leave her room.

Observation on the 100 hall on 10/27/21 at 4:15pm revealed:
-A resident was crying outside her room.
-She told the staff another resident told her to return to her room because they were still quarantined.
-She stated she did not want to go back to her room.

Interview with the Business Office Manager (BOM) on 10/27/21 at 10:55am revealed the residents were not eating in the dining room at this time due to the recent COVID outbreak.

Interview with the Dietary Manager (DM) on 10/27/21 at 11:45am revealed:
-He prepared boxed meals for all of the residents' meals due to the recent COVID outbreak.
-The Executive Director (ED) had planned to allow communal dining on 11/01/21 if the last round of COVID tests were all negative.

Interview with the Acting Administrator on 10/27/21 at 11:45am revealed:
-Per the Health Department's guidance, the facility's 28 day quarantine, due to their COVID outbreak status, ended on 10/21/21.
-She was not aware all of the residents were eating in their room and expected them to be eating in the dining room since the outbreak status had ended 6 days ago.
-She made arrangements for communal dining to start at the lunch meal service on 10/27/21.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL090007 | A. BUILDING: _____ B. WING _____ | 10/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE UNION PARK | 1316 PATTERSON AVENUE MONROE, NC 28112 |

| (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 338 | Continued From page 10<br><br>Observation on 10/27/21 at 11:55am revealed staff visited residents' rooms to inform them that communal dining was an option for lunch today and was available for dinner that night.<br><br>Observation of the lunch meal service at on 10/27/21 at 12:15pm revealed 9 residents ate lunch in the dining room.<br><br>Interview with a resident on 10/27/21 at 12:32 pm revealed:<br>-A boxed meal for lunch was delivered to her room today.<br>-She heard other resident talking about going to the dining room to eat lunch but was not told that she could eat in the dining room.<br>-She felt left out and was visibly upset.<br><br>Observation of the breakfast meal service on 10/28/21 at 7:15am revealed 31 residents ate in the dining room.<br><br>Interview with 5 residents during breakfast on 10/28/21 from 7:21am to 7:45am revealed:<br>-One resident ate dinner in the dining room last night and breakfast in the dining room this morning and was very happy that things were getting "back to normal".<br>-A second resident really enjoyed eating with her friends.<br>-A third resident liked eating with other people instead of eating alone.<br>-A fourth resident liked eating in a group so he could see everyone and catch up on the news.<br>-A fifth resident had recently lost his spouse and was glad to eat with friends.<br><br>Telephone interview with a resident's family member on 10/28/21 at 10:04am revealed her mother had been depressed recently due to being | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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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 338 | Continued From page 11<br>kept in her room and not interacting with other people. | D 338 | | |