| 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 _____ | 09/08/2022 |

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| BROOKDALE CHARLOTTE EAST | 6053 WILORA LAKE ROAD CHARLOTTE, NC 28212 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Mecklenburg County DSS conducted an Annual Survey on September 7-8, 2022. | D 000 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on interviews, and record reviews, the facility failed to assure contact with a medical professional for 1 out of 5 sampled residents (#4) resulting in Resident #4 not being administered her levothyroxine sodium for hypothyroidism.<br><br>The findings are:<br><br>Interview with Resident #4 on 09/07/22 at 9:20am revealed:<br>-She had not been getting her thyroid medication in the morning for about 3 months.<br>-She had mentioned it to the third shift medication aid, (MA).<br><br>Review of Resident #4's current FL2 dated 06/29/22 revealed:<br>-Diagnoses included chronic kidney disease, essential hypertension, gastroesophageal disease and hypothyroidism.<br>-There was a physician's order for levothyroxine sodium (a medication used to treat hypothyroidism) 75mcg every day at 5:30am.<br><br>Review of Resident #4's July, August, and September 2022 electronic Medication Administration Record (eMAR) revealed: | D 273 | | |

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| D 273 | Continued From page 1 | D 273 | | |

-There was a computer generated entry for levothyroxine sodium 75mcg one tablet daily scheduled to be administered at 5:30am.
-In July 2022 the levothyroxine sodium 75mcg was not documented as administered 19 times from 07/01/22 to 07/31/22.
-In August 2022 the levothyroxine sodium 75mcg was not documented as administered 18 times from 08/01/22 to 08/31/22.
-In September 2022 the levothyroxine sodium 75mcg was not documented as administered 5 times from 09/01/22 to 09/07/22.

Interview with Resident #4's PCP on 09/07/22 at 10:45am revealed:
-She did not know that Resident #4 had not been receiving her levothyroxine.
-She had just spoken with Resident #4 and she did not mention to her about not receiving her levothyroxine.
-She would have expected the facility to notify her about not receiving the levothyroxine.
-Resident #4's last TSH (a lab that measures thyroid levels) was done on 06/06/22 and was 3.82 (therapeutic range 0.46 to 4.68).
-She had seen the resident on several occasions within the past few months including today and the resident did not seem to be having any symptoms of not receiving her thyroid medications.
-Some of the symptoms Resident #4 could have are increased depression, lethargy, and being excessively tired or fatigued, gastrointestinal issues constipation / diarrhea, irritability, and weight gain if she didn't get her levothyroxine as ordered.
-There was not documentation Resident #4's PCP was notified.

Interview with the Resident Care Coordinator

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| D 273 | Continued From page 2 | D 273 | | |

(RCC) on 09/08/22 at 1:01am revealed:
-She was responsible for the medication aides working the medication carts.
-She normally ran a missed medication list when she done the chart audits.
-She had completed a missed medication list when she completed the chart audit on the lower floor last month.
-It had been several months since she had completed a chart audit for the upper floor; therefore, she was not aware Resident #4 missed her levothyroxine and the provider was not notified.

Interview with the Health and Wellness Director (HWD) on 09/07/22 at 2:48pm revealed:
-It was the Resident Care Coordinator's (RCC) responsibility to do missed medication audits.
-All the missed medications were the responsibility of one specific medication aide on third shift.
-The medication aide had spoken with our district Nurse and had misunderstood her instructions.
-The medication aide was supposed to give the medication right before she left on third shift, but instead left them for first shift to administer.
-The medication aide had not told first shift that the medication had not been administered.
-She had not notified the provider because she did not know Resident #4 was not getting the medications.

Interview with the Administrator on 09/08/22 at 12:45am revealed:
-It was the responsibility of the HWD to make sure that all medications were administered.
-She let the HWD manage the assisted living unit.

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| D 309 | Continued From page 3 | D 309 | | |
| D 309 | 10A NCAC 13F .0904(e)(3) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record review, the facility failed to maintain an accurate and current list of residents that required physician ordered therapeutic diets for 1 of 4 sampled residents related to a low cholesterol, low fat diet (#4).<br><br>The findings are:<br><br>Review of Resident #4's current FL2 dated 06/29/22 revealed:<br>-Diagnoses included essential hypertension and gastroesophageal disease.<br>-An order for a low cholesterol, low fat diet.<br><br>Review of the therapeutic diet list posted in the kitchen on 09/07/22 at 9:33am revealed:<br>-The list was dated 07/14/22.<br>-Resident #4 was on a regular diet and preferred to drink sweet tea.<br><br>Review of the therapeutic diet list in the diet binder located in the kitchen dated 09/02/22 revealed Resident #4 was on a regular diet and preferred to drink sweet tea. | D 309 | | |

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| D 309 | Continued From page 4<br><br>Interview with dietary aide on 09/07/22 at 9:20am revealed she did not know who made the therapeutic diet list but the Food Service Director (FSD) delivered the updated lists.<br><br>Interview with a second dietary aide on 09/07/22 at 1:15pm revealed:<br>-She referenced the therapeutic diet list to accurately serve meals to the residents.<br>-According to the therapeutic diet list, Resident #4 was on a regular diet.<br><br>Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 12:24pm revealed:<br>-She brought a paper copy of residents' diet orders to the kitchen whenever a new resident was admitted or a diet was changed.<br>-She verbally updated kitchen staff on the new diet order and expected them to put the order in the diet binder located in the kitchen.<br>-The new diet order was typically on the "Physician Diet Order" sheet but sometimes other documents with signed orders were used to communicate a new diet order.<br>-She was not sure who made the therapeutic diet list and she did not audit the list for accuracy once it was posted.<br><br>Interview with the Health and Wellness Director (HWD) on 09/08/22 at 10:15am revealed:<br>-The FSD updated the therapeutic diet list for the kitchen.<br>-Whenever a resident was admitted or if a resident's diet order changed, she or the RCC were responsible for giving the order to the FSD.<br>-She gave the FSD a paper copy of the diet order or sent it via email.<br>-If the order was on a FL2 or in a provider's progress note then a copy of that document would be given to the FSD. | D 309 | | |

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| D 309 | Continued From page 5 | D 309 | | |

-The diet orders were also updated in the facility's electronic database.
-She did not audit the therapeutic diet list in the kitchen and was not aware Resident #4's diet was incorrect.

Interview with the FSD on 09/08/22 at 12:35pm revealed:
-She was responsible for updating the therapeutic diet list.
-The RCC or HWD only provided her with paper copies of the "Physician's Diet Order" sheet when there was a new diet order.
-She did not have access to the resident's orders or the facility's electronic database of diet orders.
-She updated the therapeutic diet list whenever a resident was admitted or if a diet order changed.
-She was not aware that Resident #4's diet changed from regular to low cholesterol, low fat on 06/29/22.
-The managers attend a meeting twice a month were they discuss weight loss and diet orders but no one brought to her attention that Resident #4's diet order had changed.

Interview with Resident #4's Primary Care Provider (PCP) on 09/07/22 at 4:06pm revealed:
-Resident #4's diet was changed to low cholesterol, low fat due to slightly elevated triglycerides and her history of a stroke.
-She wrote the order on Resident #4's FL2 dated 06/29/22.

Interview with the Administrator on 09/08/22 at 1:00pm revealed:
-The HWD was responsible for ensuring the PCP filled out a "Physician Diet Order" sheet when a resident was admitted or a diet order was changed.
-The "Physician Diet Order" sheet was given to

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| D 309 | Continued From page 6<br>the FSD so she could update the therapeutic diet list.<br>-The HWD, RCC, Administrator and FSD met twice a month to discuss resident weight loss and diet changes.<br>-No one was currently responsible for auditing the therapeutic diet list. | D 309 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents related to administering a medication used to treat hypothyroidism (Resident #4).<br><br>The findings are:<br><br>Interview with Resident #4 on 09/07/22 at 9:20am revealed:<br>-She had not been getting her thyroid medication in the morning for about 3 months.<br>-She had received all her other medications on time.<br>-She had not been feeling any different, she just knew that she was missing her morning thyroid medication. | D 358 | | |

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| D 358 | Continued From page 7<br>-She had mentioned it to the third shift medication aid, but no one else.<br><br>Review of Resident #4's current FL2 dated 06/29/22 revealed:<br>-Diagnoses included chronic kidney disease, essential hypertension, gastroesophageal disease and hypothyroidism.<br>-There was a physician's order for levothyroxine sodium 75mcg every day at 5:30am.<br><br>Review of Resident #4's July 2022 electronic Medication Administration Record (eMAR) revealed:<br>-There was a computer-generated entry for levothyroxine sodium 75 mcg 1 tabled daily, and scheduled to be administered at 5:30am.<br>-The levothyroxine sodium 75mcg was not administered for 19 times from 07/01/22 through 07/31/22.<br><br>Review of Resident #4's August 2022 electronic Medication Administration Record (eMAR) revealed:<br>-There was a computer-generated entry for levothyroxine sodium 75 mcg 1 tabled daily, and scheduled to be administered at 5:30am.<br>-The levothyroxine sodium 75mcg was not administered for 18 times from 08/01/22 through 08/31/22.<br><br>Review of Resident #4's September 2022 electronic Medication Administration Record (eMAR) revealed:<br>-There was a computer-generated entry for levothyroxine sodium 75 mcg 1 tabled daily, and scheduled to be administered at 5:30am.<br>-The levothyroxine sodium 75mcg was not administered for 5 times from 09/01/22 through 09/07/22. | D 358 | | |

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| D 358 | Continued From page 8<br><br>Observation of medication on hand for Resident #4 on 07/08/22 at 10:15am revealed there was two pharmacy dispensed bubble packs:<br>-One of the bubble cards had a dispense date of 07/20/22 and had 15 remaining tablets on the card.<br>-A second bubble card had a dispense date of 8/18/22 and had 27 remaining tablets on the card.<br><br>Interview with Resident #4's Primary Care Provider (PCP) on 09/07/22 at 10:45am revealed:<br>-She did not know that Resident #4 had not been receiving her levothyroxine.<br>-She had just spoken with Resident #4 and she did not mention to her about not receiving her levothyroxine.<br>-She would have expected the facility to notify her about not receiving the levothyroxine.<br>-Resident #4's last TSH (a lab that measures thyroid levels) was done on 06/06/22 and was 3.82 (therapeutic range 0.46 to 4.68).<br>-She had seen the resident on several occasions within the past few months including today and the resident did not seem to be having any symptoms of not receiving her thyroid medications.<br>-Some of the symptoms Resident #4 could have are increased depression, lethargy, and being excessively tired or fatigued, gastrointestinal issues constipation / diarrhea, irritability, and weight gain if she didn't get her levothyroxine as ordered.<br><br>Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 1:01am revealed:<br>-She was responsible for the medication aides working the medication carts.<br>-She normally ran a missed medication list when she done the chart audits. | D 358 | | |

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| D 358 | Continued From page 9<br>-She had completed a missed medication list when she completed the chart audit on the lower floor last month.<br>-It had been several months since she had completed a chart audit for the upper floor; therefore she was not aware Resident #4 missed her levothyroxine in July, August and September.<br><br>Interview with the Health and Wellness Director (HWD) on 09/07/22 at 2:48pm revealed:<br>-It was the Resident Care Coordinator's (RCC) responsibility to do missed medication audits.<br>-All the missed medications were the responsibility of one specific medication aide on third shift.<br>-The medication aide had spoken with our district Nurse and had misunderstood her instructions.<br>-The medication aide was supposed to give the medication right before she left on third shift, but instead left them for first shift to administer.<br>-The medication aide had not told first shift that the medication had not been administered.<br><br>Interview with the Administrator on 09/08/22 at 12:45am revealed:<br>-It was the responsibility of the HWD to make sure that all medications were administered.<br>-She let the HWD manage the assisted living unit. | D 358 | | |