STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

(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 December 10, 2019 through December 12, 2019.	D 000		
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 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 3 of 7 residents (#3, #6, #7) observed during the medication passes including errors with an oral diabetic medication (#3), Omega 3 Fish Oil (#6), a medication for Parkinson's disease (#7) and 1 of 5 sampled residents (#4) who was administered the wrong dosage of a medication used for anxiety. The findings are: 1. The medication error rate was 12% as evidenced by the observation of 3 errors out of 25 opportunities during the lunch and afternoon medication passes on 12/10/19 and during the breakfast and lunch medication passes on 12/11/19. a. Review of Resident #3's current FL-2 dated 08/05/19 revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 1	D 358		

-Diagnoses included Type II diabetes mellitus (DM), hyperlipidemia, insomnia, osteoarthritis, intervertebral disc degeneration lumbosacral region, atherosclerotic heart disease and coronary deficiency without angina pectoris.
-There was an order for Metformin 500mg twice a day (Metformin is used to help control blood sugar for diabetes).

Review of Resident #3's physician's order summary dated 10/28/19 revealed there was a medication order for Metformin 500mg give one tablet two times a day for DM, with meals at 8:00am and 5:00pm.

Observation during the lunch medication pass on 12/10/19 at 12:15pm revealed:
-The Resident Care Coordinator/Medication Aide (RCC/MA) removed a blister pack labeled Metformin 500 mg take one tablet twice a day with meals, from the medication cart drawer and punched two tablets into a souffle cup.
-The RCC/MA carried the souffle cup with the Metformin 500 mg two tablets to Resident #3 eating lunch and observed while the resident swallowed the medication.
-The RCC/MA returned to the medication cart and documented on Resident #3's electronic Medication Administration Record (eMAR).

Review of Resident #3's December 2019 eMAR revealed:
-There was a computer-generated entry for Metformin 500mg give one tablet two times a day for DM with meals at 8:00am and 5:00pm.
-Metformin was scheduled to be administered at 12:00pm and 9:00pm.

Review of Resident #3's October, November and December 2019 eMARs revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

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D 358	Continued From page 2 -There was a computer-generated entry for Metformin 500mg give one tablet two times a day for DM with meals at 8:00am and 5:00pm. -Metformin was scheduled to be administered at 12:00pm and 9:00pm. -Metformin 500mg one tablet two times a day for DM with meals at 8:00am and 5:00pm was documented as administered on 12/10/19 at 12:00pm. -Metformin 500mg one tablet two times a day for DM with meals at 8:00am and 5:00pm was documented as administered at 12:00pm and 9:00pm from 12/03/19 to 12/09/19. -Metformin 500mg one tablet two times a day for DM with meals at 8:00am and 5:00pm was documented as administered at 12:00pm from 10/01/19 to 10/25/19 and from 10/27/19 to 10/31/19 and at 9:00pm on 10/01/19, 10/07/19, from 10/09/19 to 10/12/19 and from 10/14/19 to 10/18/19 and from 10/22/19 to 10/29/19 and on 10/31/19. -Metformin 500mg one tablet two times a day for DM with meals at 8:00am and 5:00pm was documented as administered at 12:00pm from 11/01/19 to 11/03/19 and from 11/05/19 to 11/09/19 and from 11/11/19 to 11/30/19 and at 9:00pm from 11/01/19 to 11/04/19 and from 11/06/19 to 11/08/19 and from 11/11/19 to 11/15/19, on 11/17/19, on 11/20/19 and from 11/22/19 to 11/27/19 and from 11/29/19 to 11/30/19. Interview on 12/12/10/19 at 12:48pm with the RCC/MA who administered the Metformin to Resident #3 on 12/10/19 at 12:15pm revealed: -Resident #3 always received Metformin at lunch and supper because he woke up late in the morning. -Meals were not served to Resident #3 at 9:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 3 Interview with the Health and Wellness Director (HWD) on 12/10/19 at 12:50pm who was the facility's registered nurse revealed she thought the discrepancies between the physician's order for Resident #3's Metformin 500mg and the scheduled administration times on Resident #3's eMAR may have been a result of preset administration times in the computer eMAR system placed by the pharmacy. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/11/19 at 2:50pm revealed: -The facility staff were responsible for faxing physician orders to the pharmacy. -The pharmacy was responsible for entering the physician orders into their label system and printing the labels for the medication bubble packs. -The facility staff were responsible for entering physician orders into the eMAR system. -The most current physician's order the pharmacy had received for Resident #3 was Metformin 500mg one tablet twice a day with meals dated 09/16/19. A second interview with the HWD on 12/11/19 at 2:10pm revealed: -She was not aware she could override the standard medication administration times preset in the eMAR computer system and specify administration times for medications ordered with meals. -Staff members entering orders into the eMAR system were responsible for ensuring the eMARS accurately specified medication administration times as ordered by the Primary Care Provider (PCP).	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

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D 358	Continued From page 4	D 358		

Telephone interview with Resident #3's PCP on 12/12/19 at 4:50pm revealed:
-The PCP thought the resident slept late.
-The PCP may have written another order at some time changing the Metformin administration times.
-The PCP would like the HWD to contact the PCP regarding the resident.

Attempted telephone interview with the Administrator on 12/12/19 at 4:59pm was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

Refer to interview with RCC/MA on 12/11/19 at 11:45am.

Refer to interview with the RCC/MA and HWD on 12/11/19 at 12:35pm.

Refer to interview with the HWD on 12/12/19 at 4:05pm.

Refer to interview with the HWD on 12/10/19 at 3:57pm.

Refer to interview with the Executive Director on 12/11/19 at 3:52pm.

b. Review of Resident # 6's current FL-2 dated 07/05/19 revealed diagnoses included coronary artery disease, history of myocardial infarction, hypertension, hyperlipidemia, dementia Alzheimer's Type and history of constipation.

Review of the physician's order summary sheet for Resident #6 dated 10/23/19 revealed there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

(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 5	D 358		

was a signed physician's order for Omega-3 Fish Oil Concentrate capsule delayed release 1000mg give one capsule one time a day for deficiency. (Fish Oil is a supplement used to prevent and manage heart disease).

Observation during the medication pass on 12/11/19 at 8:17am revealed:
-The Resident Care Coordinator/Medication Aide (RCC/MA) removed a blister pack labeled Fish Oil Omega 3-300-1000 take one capsule every day, from the medication cart drawer and punched one capsule into a souffle cup.
-The RCC/MA carried the souffle cup with Fish Oil Omega 3-300-1000 one capsule to Resident #6 and observed while the resident swallowed the medication.
-The RCC/MA returned to the medication cart and documented on Resident #6's electronic Medication Administration Record (eMAR).

Review of Resident #6's December 2019 eMAR revealed:
-There was a computer-generated entry for Omega-3 Fish Oil Concentrate Capsule Delayed Release 1000mg (Omega-3 Fatty Acids) give one capsule one time a day for deficiency, scheduled at 8:00am.
-There was documentation Omega-3 Fish Oil Concentrate Capsule Delayed Release 1000mg (Omega-3 Fatty Acids) one capsule was administered on 12/11/19 at 8:00am.
-There was documentation Omega-3 Fish Oil Concentrate Capsule Delayed Release 1000mg (Omega-3 Fatty Acids) one capsule was administered to Resident #6 at 8:00am from 12/01/19 to 12/11/19.

Interview on 12/11/19 at 11:27am with the RCC/MA who administered Fish Oil Omega

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

(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 6	D 358		

3-300-1000 one capsule to Resident #6 on 12/11/19 at 8:17am revealed:
-She did not know what DR (delayed release) meant on the eMAR.
-She did not notice the Fish Oil was specified as delayed release on Resident #6's eMAR and physician's order, but not on the Fish Oil blister pack label.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/11/19 at 2:50pm revealed:
-The facility staff were responsible for faxing physician orders to the pharmacy.
-The pharmacy was responsible for entering the orders into their label system and printing the labels for the medication bubble packs.
-The facility staff were responsible for entering physician orders into the eMAR system.
-The label on the Fish Oil Omega 3-300-1000 one capsule every day correctly identified the medication the pharmacy had delivered to the facility for Resident #6.
-The pharmacy was not sending Omega-3 Fish Oil Concentrate Capsule Delayed Release 1000mg for Resident #6.
-The pharmacist was not aware Fish Oil was available in a delayed release form.
-The pharmacist deferred any affects the resident may have encountered not receiving Omega-3 Fish Oil Concentrate Capsule Delayed Release to the physician.

Attempted telephone interview with Resident #6's cardiologist on 12/12/19 at 12:00pm was unsuccessful.

Attempted telephone interview with the Administrator on 12/12/19 at 4:59pm was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

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D 358	Continued From page 7 Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Refer to interview with RCC/MA on 12/11/19 at 11:45am. Refer to interview with the RCC/MA and HWD on 12/11/19 at 12:35pm. Refer to interview with the HWD on 12/12/19 at 4:05pm. Refer to interview with the HWD on 12/10/19 at 3:57pm. Refer to interview with the Executive Director on 12/11/19 at 3:52pm. c. Review of Resident # 7's current FL-2 dated 09/05/19 revealed: -Diagnoses included Type 2 Diabetes, hypertension, vascular dementia without behavioral, age related osteoporosis, hyperlipidemia, Parkinson's and major depressive disorder. -There was an order for Sinemet CR (50-200mg) two tabs with meals (Sinemet is used to treat symptoms of Parkinson's such as shakiness, stiffness and difficulty moving). Review of the physician's order summary sheet for Resident #7 dated 10/24/19 revealed there was a signed physician order for Sinemet CR Tablet Extended Release 50-200 MG give two tablets with meals for Parkinson's. Observation during the medication pass on 12/11/19 at 11:20am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

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D 358	Continued From page 8 -The Resident Care Coordinator/Medication Aide (RCC/MA) removed a blister pack labeled Sinemet 25-100mg take two tabs (50-200mg) three times a day with meals, from the medication cart drawer and punched Sinemet 25-100mg two tablets from the blister pack into a souffle cup. -The RCC/MA carried the souffle cup with Sinemet 25-100mg two tablets to Resident #7 and observed while the resident swallowed the medication. -The RCC/MA returned to the medication cart and documented on Resident #7's electronic Medication Administration Record (eMAR). Review of Resident #7's October, November and December 2019 eMARs revealed: -There was a computer-generated entry for Sinemet CR Tablet Extended Release 50-200mg two tablets with meals. -There was documentation Sinemet CR Tablet Extended Release 50-200 MG two tablets was administered on 12/11/19 at 12:00pm. -There was documentation Sinemet CR Tablet Extended Release 50-200 MG two tablets was administered from 10/01/19 to 10/31/19 at 8:00am, 12:00pm and 6:00pm, from 11/01/19 to 11/30/19 at 8:00am, 12:00pm and 6:00pm, and from 12/01/19 to 12/10/19 at 8:00am, 12:00pm and 6:00pm and 12/11/19 at 8:00am and 12:00pm. Interview on 12/11/20 at 12:20pm with the RCC/MA who administered Sinemet 25-100mg to Resident #7 on 12/11/19 at 11:20pm revealed: -She did not know what CR (controlled release) meant on the eMAR. -She was not aware the label on the medication blister pack identified the medication as Sinemet 25-100mg tablets and the eMAR specified Sinemet CR Tablet Extended Release 50-200mg	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

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D 358	Continued From page 9 give two tablets with meals. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/11/19 at 2:50pm revealed: -The facility staff were responsible for entering physician orders into the eMAR system and for faxing physician orders to the pharmacy. -The pharmacy was responsible for entering the orders into their label system and printing the medication dosage labels. -The most current physician's orders in the pharmacy computer for Resident #7 was for Sinemet 25-100mg two tabs three times a day with meals signed 08/22/18. -Sinemet 25-100mg had been delivered to the facility for Resident #7 and not Sinemet CR Extended Release 50-200 mg. -The pharmacy did not have a copy of Resident #7's FL-2 dated 09/05/19 with an order for Sinemet CR (50-200mg) two tabs with meals. -The pharmacy did not have a copy of Resident #7's physician's orders dated 10/24/19 for Sinemet Extended Release 50-200 MG two tablet with meals for Parkinson's. -The pharmacist deferred any effects the resident may experience from receiving Sinemet 25-100mg not Sinemet Extended Release 50-200 MG two tablets to the resident's primary care provider (PCP). Interview with Resident #7's PCP on 12/12/19 at 11:40am revealed: -She had been made aware of the medication that had been provided to Resident #7. -She changed the order on the FL-2 that morning (12/12/19) to Sinemet 25-100mg take 2 tablets (50-200mg) three times a day with meals, which reflected the dose and medication Resident #7 had been receiving.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

(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 10 Attempted telephone interview with the Administrator on 12/12/19 at 4:59pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable. Refer to interview with RCC/MA on 12/11/19 at 11:45am. Refer to interview with the RCC/MA and HWD on 12/11/19 at 12:35pm. Refer to interview with the HWD on 12/12/19 at 4:05pm. Refer to interview with the HWD on 12/10/19 at 3:57pm. Refer to interview with the Executive Director on 12/11/19 at 3:52pm. 2. Review of the facility's medication administration policies revealed: -Staff should check the label three time to verify the right medication and right dose before giving the medication. -Staff should follow the seven rights of medication administration for right medication, right dose, right time, right route, right resident, right documentation, and right to refuse. -Medication on the physician's order and the pharmacy label should correlate with the medication on the eMAR. Review of Resident #4's current FL-2 dated 08/29/19 revealed: -Diagnoses included dementia without behavior	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

(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 11	D 358		

disturbances, arthritis, sleep apnea, and benign prostatic hypertrophy.
-There was an order for Ativan 0.5mg - 1 tablet every six hours as needed for anxiety (Ativan is used to treat anxiety.).

Review of physician's order summary sheet for Resident #4 dated 10/23/19 revealed there was a signed physician order for Ativan 0.5mg - 1 tablet every six hours as needed for anxiety.

Review of Resident #4's previous FL-2 dated 07/12/18 revealed there was an order for Ativan 0.5mg - 1 tablet every six hours as needed for anxiety.

Review of a physician's order dated 06/13/18 revealed there was a medication order for Ativan 0.5mg take one half tablet every six hours as needed for anxiety/agitation.

Review of Resident #4's electronic medication administration records (eMAR) from March 2019 through December 2019 revealed:
-There was a computer-generated entry for Ativan 0.5mg take one tablet every six hours as needed for anxiety/agitation on each eMAR.
-There was documentation Ativan 0.5mg - 1 tablet was administered on 11/04/19 on the November 2019 eMAR.
-There was no other documentation that staff administered Ativan 0.5mg to Resident #4 on the remaining eMARs.

Review of Resident #4's control substance log on 12/11/19 revealed:
-The control substance log was labeled with dosage instructions for Ativan 0.5mg "take ½ tablet by mouth every six hours as needed for anxiety/agitation".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

(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 12	D 358		

-One hundred and twenty - ½ tablets of Ativan 0.5mg were checked in the facility on 06/14/18.
-It was documented Ativan 0.5mg - ½ tablet (0.25mg) was administered to Resident #4 on 03/17/19, 03/24/19, 06/03/19, 08/03/19, 08/18/19, 11/04/19, and 12/09/19 and was administered by the same medication aide for all seven doses.

Observation of Resident #4's medications on hand on 12/11/19 revealed there were three blister packs of Ativan 0.5mg that contained 30 - ½ tablets (0.25mg) and a fourth blister pack that contained 23 remaining ½ tablets of Ativan 0.5mg.

Telephone interview with the medication aide (who documented administering all the Ativan doses to Resident #4) on 12/12/19 at 9:26am revealed:
-She last administered Ativan to Resident #4 on 12/09/19 before dinner because he was agitated.
-If she signed Resident #4's control log then she administered Ativan 0.5mg - ½ tablet to Resident #4.
-She did not read the labels on Resident #4's Ativan or verify Resident #4's Ativan dosage was correct according to Resident #4's eMAR.
-She was supposed to ensure she administered the correct dosage of medications to the residents by comparing the medication labels against the medication she was administering.
-She never checked the medication labels against the eMAR before she administered medications to the residents because she "did not have the time because she was taking care of residents".
-She did not know Ativan 0.5mg - 1 tablet was supposed to administered instead of a ½ tablet as she had administered.

Interview with the Resident Care Coordinator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

(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 13	D 358		

(RCC) on 12/10/19 at 1:55pm revealed:
-She was not sure if Resident #4 was still taking Ativan 0.5mg or the last time Ativan was administered to Resident #4.
-She did not realize there were only ½ tablets of Ativan 0.5mg on the medication cart for Resident #4.
-She had not noticed there was a discrepancy between the dosage of Ativan tablets on hand and what Resident #4's medication order was for.
-The medication aides should read the dosage labels on the medications and ensure the medication dosages are correct prior to administering medications.
-She did not know if the medication carts were audited to ensure the correct medications were on the medication cart for the residents.
-No medications cart audits had been completed at the facility since she started working in July 2019.
-She and the Health Wellness Director (HWD) would be responsible for medication carts audits if they were being done.

Interview with the HWD on 12/12/19 at 1:05pm revealed:
-She was a registered nurse and had worked at the facility for a year and a half.
-She did not know Resident #4 was supposed to have a whole tablet of Ativan 0.5mg instead of ½ tablet as needed for anxiety.
-She had not noticed the Ativan dosage had changed on Resident #4's FL-2s dated 07/12/18 or 08/29/19 or the physician's order summary sheet dated 10/23/19.
-She and the RCC were responsible to ensure all residents' medications coincided with their FL-2s and updated physician's order summaries.
-She and the RCC checked the medications on the medication cart monthly against the current

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

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D 358	Continued From page 14	D 358		

medications for the residents, but the change in Resident #4's Ativan dosage had been missed.
-The medication aides should read the dosage labels of all medications and comparing them with the residents' eMARs prior to administration of medications.
-There was no current policy for staff to perform medication cart audits in the facility.

Telephone interview with Resident #4's primary care provider (PCP) on 12/12/19 at 10:00am revealed:
-She took over care of Resident #4 in March 2019.
-Resident #4's current Ativan dosage was supposed to be 0.5mg - 1 tablet every 6 hours as needed according to the last physician's order summary sheet she signed.
-She expected staff to administer the medications as ordered by the primary care provider.
-She could not remember writing a prescription for Resident #4's Ativan, but the medication order on the last physician's order summary sheet was correct.

Interview with the Executive Director on 12/12/19 at 3:25pm revealed:
-It was her expectation that the medication aides should ensure medications were administered as ordered by the PCP.
-The medication aides should read the medication labels and ensure the eMARs coincide.
-The facility did not have any policies in place of who was responsible to ensure the correct medications were on the medication carts for the residents.
-The HWD and the RCC might check the medications in the medication carts but there was no policy in place at the facility of who was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

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BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

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D 358	Continued From page 15 responsible to ensure the medications were correct according to the medication orders. Attempted telephone interview with the Administrator on 12/12/19 at 4:58pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. _____ Interview with the RCC/MA on 12/11/19 at 11:45am revealed: -She received copies of physician's orders and listed them on a tracking sheet. -When she received medications from the pharmacy, she checked her tracking book and located the order. -She checked to make sure the labels on the medications correctly matched the physician orders and placed the medications in the medication cart. -The HWD was responsible for reviewing PCP medication orders to ensure medication orders were appropriate for the resident after the RCC/MA placed the medication blister packs in the medication carts. -She had not checked the label on all medications delivered against the orders on the eMARs. -Medications were also received from the pharmacy by the MAs who worked night shifts. Interview with the RCC/MA and HWD on 12/11/19 at 12:35pm revealed: -The pharmacy reviewed residents' medications at the facility every three months. -The HWD, RCC and all MAs entered new orders into the eMAR system. -Medication deliveries from the pharmacy routinely arrived on night shift.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 16 -The night shift MAs checked the medication labels against the pharmacy delivery slip before they placed the medications in the medication cart. -The night shift MAs did not review the eMAR entries, medication labels and physician orders to ensure all were identical prior to placing the medications in the medication cart. Interview with the HWD on 12/12/19 at 4:05pm revealed the HWD periodically reviewed random eMARs for order compliance but did not check all resident eMARs every month for order compliance. Interview with the HWD on 12/10/19 at 3:57pm revealed: -The eMARs were reviewed by the RCC or HWD to identify doses not administered every Monday. -A pharmacist reviewed resident medications, eMARS and records every three months to ensure accuracy. -Every three months the RCC/MA or HWD checked to ensure the physicians orders had been sent to the pharmacy. Interview with the Executive Director on 12/11/19 at 3:52pm revealed: -It was her expectation that the HWD ensured medications were administered as ordered. -The RCC and HWD were responsible for the accuracy of physician orders and eMARs. -The RCC and HWD were responsible for all clinical issues. -The facility had no policies on auditing eMARs, medication carts or medication orders. -She was not aware of any audits completed on eMARs, the medication carts or medication orders since she became the Executive Director.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 17	D 367		
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; (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 interviews and record reviews, the facility failed to assure the electronic Medication Administration Records (eMARs) were accurate to include the initials of the medication aide (MA)	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

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BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

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D 367	Continued From page 18 who administered a PRN (as needed) controlled substances for anxiety for six doses administered from March 2019 through December 2019 for 1 of 5 sampled residents (Resident #4). The findings are: Review of Resident #4's current FL-2 dated 08/29/19 revealed: -Diagnoses included dementia without behavior disturbances, arthritis, sleep apnea, and benign prostatic hypertrophy. -There was an order for Ativan 0.5mg every six hours as needed for anxiety (Ativan is used to treat anxiety.). Review of Resident #4's previous FL-2 dated 07/12/18 revealed there was an order for Ativan 0.5mg every six hours as needed for anxiety. Review of Resident #4's control substance logs revealed there was documentation Ativan 0.5mg was administered to Resident #4 on 03/17/19, 03/24/19, 06/03/19, 08/03/19, 08/18/19, 11/04/19, and 12/09/19 and it was administered by the same medication aide (MA) for all seven doses. Review of Resident #4's March 2019 eMAR revealed there was a computer-generated entry for Ativan 0.5mg take one tablet every six hours as needed for anxiety/agitation and there was no documentation Ativan 0.5mg was administered to Resident #4 from 03/01/19 through 03/31/19. Review of Resident #4's June 2019 eMAR revealed there was a computer-generated entry for Ativan 0.5mg take one tablet every six hours as needed for anxiety/agitation and there was no documentation Ativan 0.5mg was administered to Resident #4 from 06/01/19 through 06/30/19.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 19 Review of Resident #4's August 2019 eMAR revealed there was a computer-generated entry for Ativan 0.5mg take one tablet every six hours as needed for anxiety/agitation and there was no documentation Ativan 0.5mg was administered to Resident #4 from 08/01/19 through 08/31/19. Review of Resident #4's November 2019 eMAR revealed there was a computer-generated entry for Ativan 0.5mg take one tablet every six hours as needed for anxiety/agitation ad there was documentation Ativan 0.5mg was administered to Resident #4 on 11/04/19 at 5:26pm. Review of Resident #4's December 2019 eMAR revealed there was a computer-generated entry for Ativan 0.5mg take one tablet every six hours as needed for anxiety/agitation and there was no documentation Ativan 0.5mg was administered to Resident #4 from 12/01/19 through 12/12/19. Telephone interview with the MA (who documented administering all of the Ativan doses on Resident #4's control log) on 12/12/19 at 9:26am revealed: -She did not always document when she administered Ativan to Resident #4 on the eMAR because she was busy taking care of the residents at the facility. -Her signature on Resident #4's control substance log was documentation she administered Ativan 0.5mg to Resident #4. -She documented on Resident #4's control substance log to ensure the narcotic count was accurate for his Ativan. -She last administered Ativan to Resident #4 on 12/09/19 before dinner because he was agitated. -She could not remember if she documented on the eMAR that she administered Resident #4's	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 20 Ativan on 12/09/19. -She knew from her medication aide training she was supposed to document the Ativan administration on Resident #4's eMAR and control substance log. Interview with the Resident Care Coordinator (RCC) on 12/12/19 at 9:50am revealed: -The MAs were supposed to document all medication administration on the residents' eMARs. -The MAs were supposed to document controlled substances administered on the residents' eMARs and control substance logs. -She did not know the MA was only documenting the administration of Resident #4's Ativan on his control substance logs and not his eMARs. -It was her expectation that all MAs document on the eMAR immediately after medications were administered. -There was no policy in place at the facility to check if the MAs were documenting medications administered on the residents' eMARs. Interview with the Health Wellness Director (HWD) on 12/12/19 at 1:05pm revealed: -She did not check the residents' eMARs to assure they were accurate for medication administration. -She did not check the residents' eMARs against the control substance logs to ensure accurate documentation of the medications. -There was no current policy for staff to perform any review of the eMARs to ensure MAs were accurately documenting medication administration. -The MAs should document all medication administration on the eMARs when medications were administered.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 21 Interview with the Executive Director on 12/12/19 at 3:25pm revealed: -It was her expectation that the MAs should document on the eMAR immediately after medications were administered to the residents. -She did not know the MA was not documenting on the Resident#4's eMAR when she administered controlled substances. -She did not know why the MA was not documenting on the eMAR and only documenting on the control log for controlled substances administration. -There was no policy in place at the facility to check the accuracy of the eMARs to ensure their accuracy of documentation. Attempted telephone interview with the Administrator on 12/12/19 at 4:58pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Review of the facility's medication guidelines for medication administration policy revealed: -Documentation of medications administered should occur promptly after the resident has taken the medication. -Staff should document the medication administration with full signature and/ or initials for each medication administered.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 375	Continued From page 22 who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 1 residents sampled (#5) who self-administered medications had physicians' orders to self-administer oral medications for pain relief, nausea, gas relief, depression, inhaler, suppositories, transdermal patches and a nasal spray. The findings are: Review of the facility's policy and procedure for self-administration of medications revealed: -The resident will be initially evaluated by the registered nurse (RN) to determine the resident's cognitive, physical, and visual ability to carry out the task of self-administering medications. -If the resident successfully passes the self-medication evaluation, an order should be obtained from the physician. -The RN will conduct a quarterly assessment that will include the evaluation of the resident to ensure the resident is still competent and physically able to self-administer medications. -If the RN determines during this assessment that	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 375	Continued From page 23	D 375		

the resident is not able to continue to self-administer medications, the physician will be notified of the findings and the medications should be secured for staff assistance with medication administration.
-Self-administered medications that are kept in a resident's room will be stored in a safe and secure manner to include, non-controlled medications by locking the apartment door, and controlled medications in a locked drawer or cabinet and then locking the apartment door.

Review of Resident #5's current FL-2 dated 11/15/19 revealed:
-Diagnoses included type II diabetes, heart failure, hypertension, chronic obstructive pulmonary disease, polyneuropathy, hyperlipidemia, Crohn's disease and muscle weakness.
-There was an order for Acetaminophen 650mg 1 tablet every 6 hours as needed for pain. (Acetaminophen is for pain/fever.)
-There was an order for Ondansetron 4mg, take one tablet every 8 hours as needed for nausea. (Ondansetron is for nausea.)
-There was an order for Trelegy Ellipta 100mcg/62.5mcg/25mcg inhale once per day. (Trelegy Ellipta is used for prevention of bronchospasms.)
-There was an order for Anusol HC suppositories apply one per rectum as needed. (Anusol suppositories are used for hemorrhoids.)

Review of Resident #5's Resident Register revealed:
-The resident was admitted to the facility on 07/29/16.
-The resident had adequate memory.

Review of Resident #5's current Personal Service

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

(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 375	Continued From page 24 Plan dated 03/07/19 revealed: -The resident was alert and oriented and able to verbalize her needs effectively -The resident required staff to prepare, administer, and monitor her taking her medications. -The resident had "some" medications at bedside with physician approval. -There was no list of medications that were at bedside. Observation of Resident #5's room on 12/12/19 at 1:00pm revealed: -Resident #5 had several medications on top of and inside her night stand beside her recliner and on her bathroom sink. -Resident #5 did not have a roommate. -There was a bottle of (100 tablets size) of Ibuprofen 200mg. (Ibuprofen is used for pain and inflammation.) -There was a bottle of (100 tablets size) of Simethicone 80mg. (Simethicone is used for gas relief.) -There was a Lidocaine 4% patch. (Lidocaine gel patch is for pain relief.) -There was a blister pack of Mirtazapine 15mg tablets (28 half tablets), take ½ tablet (7.5mg) at bedtime. (Mirtazapine is used for depression.) -There was a blister pack of (50 tablets size) of Acetaminophen 500mg, take 2 tablets every 6 hours as needed for pain. -There was a bottle of Ondansetron 4mg, take one tablet every 8 hours as needed for nausea. -There was an inhaler for Trelegy Ellipta 100mcg/62.5mcg/25mcg inhale once per day. -There was a bottle of Fluticasone 50mcg nasal spray, instill one spray in each nostril twice a day. (Fluticasone is used for allergy relief.) -There was a bottle of Anusol HC suppositories apply one per rectum daily.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE W ARLINGTON BOULEVARD	2105 W ARLINGTON BOULEVARD GREENVILLE, NC 27834

(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 375	Continued From page 25	D 375		

-There was a tube of Anusol hydrocortisone 2.5% cream, apply per rectum twice a day. (Anusol cream is used for hemorrhoids.)

Interview with Resident #5 on 12/12/19 at 1:00pm revealed:
-She had some medications in her room and self-administered them.
-The staff administered three-fourths of her medications to her and she self-administered about one-fourth of her medications.
-The staff did not ask her to explain each medication that she took.
-The staff did not check her medications or count what she had in her room.
-The staff did not ask her if she took her self-administered medications each day.
-She took medication at night that helped her sleep, and nasal spray to help her breathe.
-She applied the Lidocaine patch to her shoulder whenever she had pain.
-She took Ondansetron whenever she felt nauseated.
-She used her inhaler every morning.
-She used the Anusol suppositories and cream at night to help her with her hemorrhoids.
-She always kept her door locked.
-She got some medications from a local pharmacy and some medications were given to her by the staff to keep in her room.

Review of Resident #5's physician's orders revealed:
-There were no orders for the resident to receive or self-administer Ibuprofen, Simethicone, Lidocaine 4% patch, Mirtazapine, Fluticasone 50mcg nasal spray or Anusol hydrocortisone cream.
-There were no orders for the resident to self-administer Acetaminophen, Ondansetron,

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	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 375	Continued From page 26 Trelegy Ellipta or Anusol HC suppositories. Review of Resident #5's current licensed health professional support (LHPS) review dated 10/10/19 revealed there was no documentation regarding Resident #5 self-administering medications or being assessed for self-administration. Telephone interview with a physician at Resident #5's primary care provider (PCP) office on 12/12/19 at 1:50pm revealed: -Resident #5's PCP was not available, but another physician at the office also took care of Resident #5 and was able to give feedback. -Resident #5 may have been told by her PCP that she could self-administer medications, but there was not an order that he could find in their office records. -Resident #5 was alert and oriented and capable of self-administering her medications. -He would call the facility to get orders set up for Resident #5 to self-administer her medications. Interview with the Resident Care Coordinator/medication aide (RCC/MA) on 12/12/19 at 3:30pm revealed: -Resident #5 self-administered some of her medications like inhalers and nasal sprays. -She did not know if Resident #5 had a physician order to self-administer medications. -The facility policy was that a resident must have a physician's order to self-administer medications. -She knew there was other criteria for self-administration but was not sure what it entailed. -The Health and Wellness Director (HWD) was responsible for performing the self-administration assessments for residents who chose to	D 375		

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	HAL074012	A. BUILDING: _____ B. WING _____	12/12/2019

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D 375	Continued From page 27	D 375		

self-administer their medications.
-The staff did not check with the residents who self-administered medications to see if they took their medications.
-The medication aides (MA) would re-order medications if the resident told them they were out.

Interview with the HWD on 12/12/19 at 3:50pm revealed:
-She was not aware Resident #5 had any medications in her room or was self-administering any medications currently.
-The MAs should report to her if medications were found in a resident's room.
-No one had reported seeing any medications in Resident #5's room.
-The Licensed Health Professional Support (LHPS) nurse usually assessed resident's for self-administration during the quarterly reviews.
-She did not know if Resident #5 had an order for self-administration of medications.
-She was responsible for performing initial and quarterly self-administration assessments for residents who chose to self-administer their medications.
-She had not performed a self-administration assessment on Resident #5.
-Resident #5 was mentally and physically competent to self-administer her medications.

Interview with the Executive Director on 12/12/19 at 4:00pm revealed:
-She did not know of any residents in the facility who self-administered their medications.
-The HWD was responsible for performing assessments on residents who wanted to self-administer medications.
-The MAs were responsible for reporting to the HWD any medications that were in residents'

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D 375	Continued From page 28 rooms. -She did not know that Resident #5 had medications that she was self-administering. Attempted interview with the Administrator on 12/12/19 at 4:58pm was unsuccessful.	D 375		
D 394	10A NCAC 13F .1008 (c) (d) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances. (d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the	D 394		

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D 394	Continued From page 29 signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure an expired controlled substance (Ativan) was destroyed or disposed of properly for 1 of 5 residents sampled (Resident #4). The findings are: Review of Resident #4's current FL-2 dated 08/29/19 revealed: -Diagnoses included dementia without behavior disturbances, arthritis, sleep apnea, and benign prostatic hypertrophy. -There was an order for Ativan 0.5mg every six hours as needed for anxiety (Ativan is a controlled substance used to treat anxiety.). Review of Resident #4's previous FL-2 dated 07/12/18 revealed there was an order for Ativan 0.5mg every six hours as needed for anxiety. Review of a physician's order dated 06/13/18 revealed there was a medication order for Ativan 0.5mg take one half tablet every six hours as needed for anxiety/agitation.	D 394		

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D 394	Continued From page 30	D 394		

Review of Resident #4's electronic medication administration records (eMAR) from March 2019 through December 2019 revealed:
-There was a computer-generated entry for Ativan 0.5mg take one tablet every six hours as needed for anxiety/agitation on each eMAR.
-There was documentation Ativan 0.5mg - 1 tablet was administered on 11/04/19 on the November 2019 eMAR.
-There was no other documentation that staff administered Ativan 0.5mg to Resident #4.

Review of Resident #4's control substance log on 12/11/19 revealed:
-The control substance log was labeled with dosage instructions for Ativan 0.5mg read 'take ½ tablet by mouth every six hours as needed for anxiety/agitation'.
-One hundred and twenty - ½ tablets of Ativan 0.5mg were checked into the facility on 06/14/18 and labeled it expired on 06/14/19.
-It was documented Ativan 0.5mg - ½ tablet was administered to Resident #4 on 08/03/19, 08/18/19, 11/04/19, and 12/09/19 after its expiration date.
-The four doses of Ativan were administered by the same medication aide (MA).

Observation of Resident #4's medications on hand on 12/11/19 revealed 113 - ½ tablets of Ativan 0.5mg remained that were originally dispensed on 06/14/18 and labeled it expired on 06/14/19.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

Telephone interview with the pharmacist at the facility's contract pharmacy on 12/11/19 at

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D 394	Continued From page 31 2:50pm revealed: -Ativan 0.5mg was last dispensed for Resident #4 on 06/14/18 and had an expiration date of 06/14/19. -Any unused Ativan should have been returned to the pharmacy by the facility when it expired on 06/14/19. -No Ativan had been returned to the pharmacy for Resident #4. Telephone interview with the MA (who documented administering Ativan to Resident #4) on 12/12/19 at 9:26am revealed: -She last administered Ativan to Resident #4 on 12/09/19 before dinner because he was agitated. -If she signed Resident #4's control log then she administered the Ativan to Resident #4. -She had not noticed Resident #4's Ativan was expired when she administered the last four doses of Ativan to Resident #4 because she did not check the expiration date on Resident #4's Ativan. -She did not check any medications "regularly" for their expiration dates when she administered medications. -She knew from her medication aide training that expired medications should not be given to any residents and expired controlled substances were supposed to be returned to the pharmacy. Interview with the Resident Care Coordinator on 12/10/19 at 1:55pm revealed: -She was not sure if Resident #4 was still taking Ativan 0.5mg or the last time Ativan was administered to Resident #4. -She had not noticed Resident #4's Ativan on the medication cart was expired. -Expired medications were usually removed from the medication cart by the staff on third shift; but any MA who found expired medications could	D 394		

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D 394	Continued From page 32 return them to the pharmacy including controlled substances. -There was no policy in place for how often staff were supposed to check the medication cart for expired controlled substances or other medications. Interview with the Health Wellness Director on 12/12/19 at 1:05pm revealed: -She never checked the medication carts for expired controlled substances or any other medications. -Any MA could remove expired controlled substances from the medication cart and return them back to the pharmacy. -There was no current policy for how often staff were supposed to check the medication cart for expired controlled substances or other medications. Interview with the Executive Director on 12/12/19 at 3:25pm revealed: -Expired controlled substances and medications could be sent back to the pharmacy by any of the staff who administered medications. -There was no policy in place for how often the medication carts were checked for expired controlled substances or medications. Attempted telephone interview with the Administrator on 12/12/19 at 4:58pm was unsuccessful. Review of the facility's medication administration policies revealed that staff should check the expiration dates on medication labels prior to administration.	D 394		