STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096014	A. BUILDING: _____ B. WING _____	C 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BERKLEY BOULEVARD	1800 N BERKLEY BLVD GOLDSBORO, NC 27534

(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 completed an annual survey on 08/24/21 through 08/26/21.	D 000		
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 observations, record reviews, and interviews the facility failed to ensure the medication administration record was accurate for 2 of 3 residents sampled (#1 and #3) related to insulin (#1) and a medication for anxiety (#3). The findings are: 1. Review of Resident #1's current FL-2 dated	D 367		

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D 367	Continued From page 1 10/02/20 revealed diagnoses included type 2 diabetes. Review of a Resident #1's physician's orders dated 03/11/21 revealed an order for Humalog insulin, inject 2 units with meals for a blood sugar over 250 (Humalog insulin is used to treat high blood sugar). Review of Resident #1's June 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog insulin 2 units with meals with instructions to only give if blood sugar was greater than 250. -There were two times Humalog insulin was documented as administered when the blood sugar was below the parameters of administration. -Humalog insulin was documented as administered on 06/05/21 at 5:00pm and 06/028/21 at 12:00pm. Review of Resident #1's July 2021 eMAR revealed: -There was an entry for Humalog insulin 2 units with meals with instructions to only give if blood sugar was greater than 250. -There were eight times Humalog insulin was documented as administered when the blood sugar was below the parameters of administration. -Humalog insulin was documented as administered on 07/01/21 at 08:00am, 07/03/21 at 8:00am, 07/12/21 at 12:00pm, 07/14/21 at 08:00am, 07/17/21 at 8:00am, 07/24/21 at 8:00am, 07/27/21 at 8:00am, and 07/28/21 at 8:00am. Review of Resident #1's August 2021 eMAR from	D 367		

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D 367	Continued From page 2 08/01/21 to 08/24/21 revealed: -There was an entry for Humalog insulin 2 units with meals with instructions to only give if blood sugar was greater than 250. -There were six times Humalog insulin was documented as administered when the blood sugar was below the parameters of administration. -Humalog insulin was documented as administered on 08/01/21 at 5:00pm, 08/02/21 at 12:00pm, 08/03/21 at 8:00am, 08/09/21 at 8:00am, 08/19/21 at 5:00pm, and 08/20/21 at 5:00pm. Interview with a medication aide (MA) on 08/26/21 at 8:52am revealed: -She had not administered Resident #1 Humalog insulin unless her blood sugar was over 250 even though it appeared on the eMAR that she administered it on multiple occasions. -She believed that when she signed off that the blood sugar was completed that it made it appear that it was administered when it was not. Interview with the Health and Wellness Director on 08/25/21 at 12:00pm revealed: -She expected staff to document accurately on Resident #1's eMAR including insulin administration. -Today (08/25/21), she adjusted the way that the insulin order was entered on Resident #1's eMAR so that it was clearer to staff. -She noticed that there was an issue with Resident #1's insulin documentation a couple months ago and addressed the concerns with the MAs. -She did not think that Resident #1 was receiving insulin when her blood sugar was less than 250. -She believed that staff was documenting the insulin order as completed which made the eMAR	D 367		

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D 367	Continued From page 3	D 367		

look as though it was administered, when it was not.

Interview with the Administrator on 08/26/21 at 12:02pm revealed:
-She expected Resident #1's eMAR to be accurate.
-MAs were educated monthly during staff meetings about the importance of accurate eMARs.

Interview with Resident #1's primary care provider (PCP) on 08/25/21 at 2:25pm revealed:
-She expected Resident #1's eMAR to be accurate.
-It was important Resident #1's eMAR was accurate to be able to dose medication properly and follow trends.

Based on observations and interviews, it was determined Resident #1 was uninterviewable.

2. Review of Resident #3's current FL-2 dated 03/10/21 revealed diagnoses of anxiety, insomnia, and chronic pain.

Review of a Resident #3's physician's orders dated 03/10/21 revealed an order for Xanax 0.25mg one tablet every 24 hours as needed for anxiety at bedtime.

Review of Resident #3's June 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Xanax 0.25mg one tablet every 24 hours as needed for anxiety at bedtime.
-There was documentation 21 doses of Xanax 0.25mg were administered on 06/01/21, 06/02/21, 06/03/21, 06/04/21, 06/07/21, 06/08/21, 06/10/21, 06/11/21, 06/13/21, 06/15/21, 06/17/21, 06/18/21,

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D 367	Continued From page 4 06/21/21, 06/22/21, 06/23/21, 06/24/21, 06/25/21, 06/26/21, 06/27/21, 06/28/21 and 06/29/21. Review of a controlled substance count sheet (CSCS) dated 06/01/21 through 06/29/21 revealed: -There was documentation of 24 tablets of Xanax 0.25mg signed out for Resident #3. -There were 3 tablets of Xanax 0.25mg not documented as administered on Resident #3's June 2021 eMAR; 06/12/21, 06/20/21 and 06/23/21. Review of Resident #3's July 2021 eMAR revealed: -There was an entry for Xanax 0.25mg one tablet every 24 hours as needed for anxiety at bedtime. -There was documentation 14 doses of Xanax 0.25mg were administered on 07/01/21, 07/02/21, 07/05/21, 07/06/21, 07/15/21, 07/16/21, 07/18/21, 07/20/21, 07/22/21, 07/24/21, 07/25/21, 07/28/21, 07/29/21 and 07/30/21. Review of a CSCS dated 07/01/21 through 07/30/21 revealed: -There was documentation of 18 tablets of Xanax 0.25mg signed out for Resident #3. -There were 4 tablets of Xanax 0.25mg not documented as administered on Resident #3's July 2021 eMAR; 07/07/21, 07/14/21, 07/19/21 and 07/27/21. Review of Resident #3's August 2021 eMAR revealed: -There was an entry for Xanax 0.25mg one tablet every 24 hours as needed for anxiety at bedtime. -There was documentation 6 doses of Xanax 0.25mg were administered on 08/05/21, 08/06/21, 08/07/21, 08/08/21, 08/12/21 and 08/13/21.	D 367		

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D 367	Continued From page 5 Review of a CSCS dated 08/01/21 through 08/20/21 revealed: -There was documentation of 9 tablets of Xanax 0.25mg signed out for Resident #3. -There were 3 tablets of Xanax 0.25mg not documented as administered on Resident #3's August 2021 eMAR; 08/01/21, 08/19/21 and 08/20/21. Interview with the Health and Wellness Director on 08/26/21 at 11:45am revealed: -She expected the Medication Aide (MA) to document on the eMAR when a controlled substance was administered. -She expected the MA to document the date and time a controlled substance was administered on the CSCS. -She completed audits of eMARS and the CSCS weekly and should have caught the mistake. Interview with Resident #3's primary care provider (PCP) on 08/25/21 at 2:25pm revealed: -She expected Resident #3's eMAR to be complete and accurate. -Resident #3 frequently had anxiety prior to her bedtime. -She expected MAs to correctly document when Xanax was administered to Resident #3 to ensure her anxiety was controlled. Interview with the Administrator on 08/26/21 at 12:02pm revealed: -She expected the Health and Wellness Director to audit eMARs and CSCSs to identify any problems with documentation. -She expected MAs to document correctly on the eMAR and the CSCS. -She was not sure why the MAs had not documented correctly on the eMARs.	D 367		