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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 and a follow-up survey on 03/14/23 to 03/15/23.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 3 sampled residents (#1) related to daily blood pressure checks. The findings are: Review of Resident #1's FL-2 dated 02/01/23 revealed: -Diagnoses included diabetes, hypertension, and unspecified atrial fibrillation. -There was an order to check the resident's blood pressure two times a day. Review of facility electronic progress notes revealed the resident returned to the facility from a skilled nursing home on 02/03/23. Review of Resident #1's current February 2023 electronic medication administration record (eMAR) revealed there was no entry for blood pressure checks from 02/03/23 to 02/28/23.	D 276		

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D 276	Continued From page 1 Review of Resident #1's FL-2 dated 03/07/23 revealed there was an order to check the resident's blood pressure once a day and to notify the primary care provider (PCP) if the resident's blood pressure was over 150/90. Review of Resident #1's March 2023 eMAR revealed there was no entry for blood pressure checks from 03/07/23 to 03/14/23. Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 3:07pm revealed: -The RCC or Health and Wellness Director (HWD) was responsible for entering the order for blood pressure checks on the eMAR. -The HWD had not worked at the facility since 03/08/23. -The RCC and/or HWD should have entered the order for blood pressure checks on the eMAR on 02/01/23 and 03/07/23 as ordered by primary care provider (PCP). -She was not sure how she and the HWD missed adding the blood pressure check orders on the eMAR for Resident #1. -The order for blood pressure checks should have been entered on the eMAR so that medication aides (MAs) could follow the PCP orders and notify the PCP if the resident's blood pressure was too high. Interview with the corporate Clinical Services Specialist Nurse (CSSN) on 03/15/23 at 3:18pm revealed: -The facility recorded blood pressure checks on the eMAR. -The HWD or RCC were responsible for entering PCP orders for blood pressure checks on the eMAR. -Blood pressure checks for Resident #1 should	D 276		

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have been entered on the eMAR to ensure the PCP orders were followed.

Telephone interview with Resident #1's PCP on 03/15/23 at 4:08pm revealed:
-Resident #1 had hypertension and needed his blood pressure checked to ensure his blood pressure did not become elevated.
-She was not aware that staff had not checked the resident's blood pressure as ordered.
-Staff should have followed the orders for blood pressure checks.
-She expected staff to document Resident #1's blood pressure checks twice a day as ordered on 02/01/23, after her returned to the facility on 02/03/23.
-She provided a new order with parameters for Resident #1 on 03/07/23, to check the resident's blood pressure once a day and notify the PCP if his blood pressure was over 150/90.
-Staff should have documented the resident's blood pressure and notified her if his blood pressure was over 150/90 so she could adjust his medication as needed.

Interview with the Executive Director on 03/15/23 at 2:52pm revealed:
-The HWD and/or RCC were responsible for entering PCP orders on the eMAR.
-She was not aware that staff had not followed PCP orders to check Resident #1's blood pressure.
-Staff were expected to follow PCP orders and notify the PCP if they needed clarification on any orders.

Interview with Resident #1 on 03/15/23 at 8:48am revealed he could not remember the last time staff at the facility had checked his blood pressure.

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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 2 of 4 residents (#4, #5) observed during the medication pass including errors with a medication used to thin the blood and a supplement (#5) and a diuretic medication (#4) and failing to administer a medication used treat low thyroid levels and an iron supplement (#3). The findings are: 1. The medication error rate was 10% as evidenced by the observation of 3 errors out of 28 opportunities during the 8:00 a.m. medication pass on 03/14/23. Review of the facility's medication policy dated November 2015 revealed: -Medications provided from a source should be checked by the nurse to verify the medication provided matches the current resident order. -The nurse assisting and or administering the medication must check the label 3 times to verify the right medication, right dosage, right time, and right method of administration before giving the	D 358		

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medication.
-Trained or licensed associates administering or assisting with mediations should follow the 7 Rights of Medication Administration: right medication, right dosage, right time, right route, right resident, right documentation, and right to refuse.

a. Review of Resident #5's current FL-2 dated 03/13/23 revealed:
-Diagnoses included unspecified atrial flutter (an abnormal heart rate).
-There was an order for warfarin 5mg (a blood thinner) 1 tablet on Wednesday and ½ tablet on all other days.

Review of Resident #5's Resident Register revealed he was admitted to the facility on 03/13/23.

Observation of the 8:00am medication pass on Tuesday, 03/14/23 revealed the medication aide (MA) administered 1 tablet of warfarin 5mg to Resident #5 at 8:41am.

Observation of Resident #5's medication on hand on 03/14/23 at 11:10am revealed there was a bottle of warfarin 5mg with instructions to take 1 tablet on Wednesday and ½ tablet all other days.

Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for warfarin 5mg give 0.5 tablet one time a day every Mon, Tue, Thur, Fri, Sat, Sun for prevent blood clot scheduled for administration at 8:00am.
-Warfarin 5mg 0.5 tablet was documented as administered at 8:00am on 03/14/23.
-There was an entry for warfarin 5mg 1 tablet one

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time a day every Wed to prevent blood clot scheduled at 8:00am.
-Warfarin 5mg 1 tablet was scheduled to be administered on 03/15/23.

Interview with the MA on 03/14/23 at 11:11am revealed:
-Resident #5 was admitted to the facility the afternoon of 03/13/23.
-The pharmacy had not filled Resident #5's medications yet so she was using the medications that were brought in by his family.
-The warfarin medication bottle contained whole tablets of warfarin.
-She should have administered a ½ tablet of warfarin to Resident #5 because 03/14/23 was a Tuesday.
-She did not see the instructions on the eMAR that stated Resident #5 should be administered ½ tablet of warfarin instead of a whole tablet of warfarin.

Interview with the Resident Care Coordinator (RCC) on 03/14/23 at 11:20am revealed:
-Resident #5 was admitted to the facility the afternoon of 03/13/23.
-Resident #5's FL-2 needed clarification so she had not faxed it to the pharmacy yet so they could fill his medications.
-Resident #5's family had brought in his medications from home so that was what the facility was using until they received his medications from the facility's contracted pharmacy.
-She put Resident #5's medications on the eMAR.
-The MA should have looked at the entire order for Resident #5 so she would know to administer ½ tablet of warfarin.
-She expected the MA to read the medication

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instructions carefully and compare what she was administering to what was on the eMAR.
-If the MA had questions about how Resident #5's warfarin should be administered she should have verified it with the RCC.

Interview with the Administrator on 03/15/23 at 3:54pm revealed Resident #5 not receiving the correct dose of medication could cause harm to the resident.

Interview with the facility's corporate nurse on 03/14/23 at 11:25am revealed:
-She expected MAs to follow the medication administration rights and compare the medication they were administering to what was ordered for the resident.
-Administering too much warfarin to Resident #5 could cause his blood to be too thin.

Telephone interview with Resident #5's primary care provider (PCP) on 03/14/23 at 11:40am revealed:
-He expected Resident #5 to receive the correct dosage of warfarin on the correct days.
-He would have the facility adjust Resident #5's warfarin dosage on 03/15/23.

b. Review of Resident #5's current FL-2 dated 03/13/23 revealed:
-Diagnoses included anemia and chronic kidney disease.
-There was an order for Vitamin C 500mg (a supplement) daily.

Review of Resident #5's Resident Register revealed he was admitted to the facility on 03/13/23.

Observation of the 8:00am medication pass on

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D 358	Continued From page 7 03/14/23 revealed the medication aide (MA) administered Vitamin C 1000mg to Resident #5 at 8:41am. Observation of Resident #5's medication on hand on 03/14/23 at 11:10am revealed: -There was a bottle of over-the-counter Vitamin C 1000mg. -The bottle contained whole tablets of Vitamin C. Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin C 500mg give 1 tablet one time a day for supplement scheduled for administration at 8:00am. -Vitamin C 500mg was documented as administered at 8:00am on 03/14/23. Interview with the MA on 03/14/23 at 11:11am revealed: -Resident #5 was admitted to the facility the afternoon of 03/13/23. -The pharmacy had not filled Resident #5's medications yet so she was using the medications that were brought in by his family. -She did not notice that the Vitamin C brought in by Resident #5's family contained 1000mg tablets instead of 500mg. -She should have compared the instructions on the eMAR with what was in Resident #5's Vitamin C bottle. -She should have administered ½ tablet of Vitamin C to Resident #5 instead of a whole tablet. Interview with the Resident Care Coordinator (RCC) on 03/14/23 at 11:20am revealed: -Resident #5 was admitted to the facility the afternoon of 03/13/23.	D 358		

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D 358	Continued From page 8 -Resident #5's FL-2 needed clarification so she had not faxed it to the pharmacy yet so they could fill his medications. -Resident #5's family had brought in his medications from home so that was what the facility was using until they received his medications from the facility's contracted pharmacy. -She put Resident #5's medications on the eMAR. -She did not compare the medications that were brought in by the family to what was ordered for Resident #5. -The MA should have looked at the dosage on Resident #5's Vitamin C bottle and compared it to the eMAR. -The MA should have administered ½ tablet of Vitamin C to Resident #5 instead of a whole tablet. Interview with the Administrator on 03/15/23 at 3:54pm revealed Resident #5 not receiving the correct dose of medication could cause harm to the resident. Interview with the facility's corporate nurse on 03/14/23 at 11:25am revealed: -The facility did not currently have a nurse on staff. -She worked for corporate and had just come to the facility on 03/14/23 to look over resident records. -If the facility had a nurse on staff she would expect the nurse to compare the medications that Resident #5's family brought in to what was ordered by the primary care provider (PCP). -She expected MAs to follow the medication administration rights and compare the medication they were administering to what was ordered for the resident.	D 358		

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D 358	Continued From page 9 Telephone interview with Resident #5's PCP on 03/14/23 at 11:40am revealed he expected Resident #5 to receive the correct dosage of Vitamin C. c. Review of Resident #4's current FL-2 dated 03/13/23 revealed: -Diagnoses included hyperlipidemia (high cholesterol) and hypothyroidism. -There was an order for furosemide 20mg (diuretic used to get rid of extra fluid in the body) take ½ tablet every morning. Review of Resident #4's Resident Register revealed she as admitted to the facility on 03/13/23. Observation of the 8:00am medication pass on 03/14/23 revealed the medication aide (MA) administered furosemide 20mg to Resident #4 at 8:25 am. Observation of Resident #4's medication on hand on 03/14/23 at 11:08am revealed: -There was a bottle of furosemide 20mg with instructions to take 1 tablet as needed for swelling. -The bottle contained whole tablets of furosemide. Review of Resident #4's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for furosemide 20mg give 0.5 tablet in the morning for fluid retention scheduled for administration at 9:00am. -Furosemide 20mg was documented as administered at 9:00am on 03/14/23.	D 358		

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D 358	Continued From page 10 Interview with the MA on 03/14/23 at 11:09am revealed: -She did not see on the eMAR where it was written to administer a ½ tablet of furosemide to Resident #4. -She should have administered ½ tablet of furosemide to Resident #4 instead of a whole tablet. Interview with the Resident Care Coordinator (RCC) on 03/14/23 at 11:20am revealed: -Resident #4 was admitted to the facility the afternoon of 03/13/23. -Resident #4's FL-2 needed clarification so she had not faxed it to the facility's contracted pharmacy yet so they could fill her medications. -Resident #4's family had brought in her medications from home so that was what the facility was using until they received her medications from the facility's contracted pharmacy. -She put Resident #4's medications on the eMAR. -The MA should have looked at the entire order for Resident #4 so she would know to administer ½ tablet of furosemide. -She expected the MA to read the medication instructions carefully and compare what she was administering to Resident #4 to what was on the eMAR. Interview with the Administrator on 03/15/23 at 3:54pm revealed Resident #4 not receiving the correct dose of medication could cause harm to the resident. Interview with the facility's corporate nurse on 03/14/23 at 11:25am revealed: -The facility did not currently have a nurse on staff.	D 358		

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D 358	Continued From page 11 -She worked for cooperate and had just come to the facility today to look over resident records. -She expected MAs to follow the medication administration rights and compare the medication they were administering to what was ordered for the resident. Telephone interview with Resident #4's primary care provider (PCP) on 03/14/23 at 11:40am revealed: -He expected Resident #4 to receive the correct dosage of furosemide as ordered. -There was no problem with Resident #4 receiving the wrong dosage of furosemide one time. 2. Review of the facility's medication policy dated November 2015 revealed the Community is responsible for obtaining newly ordered medication or refills for medications and treatment orders, unless otherwise agreed upon with the resident, family, or legally responsible party in accordance with the Pharmacy Service Agreement Addendum to the Residency Agreement. Review of Resident #3's current FL-2 dated 01/05/23 revealed diagnoses included hypothyroidism. a. Review of Resident #3's current FL-2 dated 01/05/23 revealed there was an order for levothyroxine sodium 100mcg every morning (Levothyroxine sodium is used to treat hypothyroidism). Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for levothyroxine sodium	D 358		

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100mcg in the morning for low thyroid hormone scheduled for administration at 6:00am.
-Levothyroxine sodium 100mcg was documented as "hospitalized" at 6:00am on 01/01/23 to 01/06/23.
-Levothyroxine sodium 100mcg was documented as administered at 6:00am on 01/07/23 to 01/11/23 and 01/31/23.
-Levothyroxine sodium 100mcg was documented as "waiting on order" at 6:00am on 01/14/23, 01/17/23 to 01/23/23, and 01/25/23/to 01/27/23.
-Levothyroxine sodium 100mcg was documented as "sleeping" at 6:00am on 01/13/23.
-Levothyroxine sodium 100mcg was documented as "medication being delivered" at 6:00am on 01/15/23.
-Levothyroxine sodium 100mcg was documented as "medication on the way" at 6:00am on 01/16/23.
-Levothyroxine sodium 100mcg was documented as "medication has to be ordered" at 6:00am on 01/24/23.
-Levothyroxine sodium 100mcg was not documented as administered at 6:00am on 01/28/23 with no explanation.
-Levothyroxine sodium 100mcg was documented as "medication on order" on 01/29/23 to 01/30/23.
-Levothyroxine sodium 100mcg was not documented as administered to Resident #3 for 19 consecutive days.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/15/23 at 2:24pm revealed:
-Resident #3's levothyroxine sodium 100mcg was on cycle fill which meant it was automatically refilled every month unless the pharmacy received an order to discontinue it.
-A 28-day supply of levothyroxine sodium 100mcg was dispensed to Resident #3 on 01/04/23.

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D 358	Continued From page 13 -A 28-day supply of levothyroxine sodium 100mcg was dispensed to Resident #3 on 01/30/23. Interview with a medication aide (MA) on 03/15/23 at 2:22pm revealed: -Most resident medications were on a cycle fill. -If a MA noticed a resident was out of a cycle fill medication, they should contact the facility's contracted pharmacy. Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 2:55pm revealed: -She was not sure why Resident #3 did not receive levothyroxine sodium for 19 days if the facility received a 28-day supply on 01/04/23. -If a MA saw that they did not have a medication on the medication cart to administer to a resident they should contact the facility's contracted pharmacy. Interview with the facility's corporate nurse on 03/15/23 at 2:55pm revealed: -Levothyroxine sodium was used to treat hypothyroidism. -Missing 19 consecutive doses of levothyroxine sodium could affect Resident #3's thyroid function which could cause her to be lethargic. Review of Resident #4's lab work collected on 02/22/23 revealed Resident #3's thyroid stimulating hormone (TSH) was 4.57 mIU/L. (TSH is a measure of how much thyroid hormone is in the blood. A thyroid level that is too high indicates that the thyroid is not making enough thyroid hormone which causes hypothyroidism. The normal lab range for TSH is 0.40 to 4.50 mIU/L). Telephone interview with Resident #3's primary care provider (PCP) on 03/15/23 at 4:07pm	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 _____	R 03/15/2023

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 14 revealed: -Levothyroxine sodium was used to treat hypothyroidism. -She was not aware that Resident #3 missed 19 consecutive doses of levothyroxine sodium in January 2023. -Resident #3 missing 19 consecutive doses of levothyroxine sodium could alter her thyroid function which could lead to palpitations, restlessness, and a change in bowel patterns. b. Review of Resident #3's current FL-2 dated 01/05/23 revealed there was an order for ferrous sulfate (an iron supplement) 325mg every 72 hours. Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed: -There was an entry for ferrous sulfate 325mg every 72 hours for iron deficiency. -Ferrous sulfate 325mg was documented as administered on 01/25/23, 01/28/23, and 01/31/23. -Ferrous sulfate 325mg was documented as "hospitalized" on 01/01/23 to 01/06/23. -Ferrous sulfate 325mg was documented as "other/see nurse notes" on 01/07/23. -Ferrous sulfate 325mg was documented as "sleeping" on 01/10/23, 01/13/23, 01/16/23, 01/19/23, and 01/22/23. -Ferrous sulfate was not documented as administered for 6 consecutive doses in January 2023. Telephone interview with the facility's contracted pharmacy on 03/15/23 at 2:24pm revealed a 28-day supply of ferrous sulfate 325mg was dispensed for Resident #3 on 01/07/23.	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 15 Interview with a medication aide (MA) on 03/15/23 at 2:22pm revealed if Resident #3 was asleep the MA should have woken her up to administer the ferrous sulfate. Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 2:55pm revealed she expected Resident #3 to receive all medications as ordered. Interview with the facility's corporate nurse on 03/15/23 at 2:55pm revealed Resident #3 not receiving ferrous sulfate as ordered could cause her blood count to be off and could cause her to be tired. Review of Resident #3's lab work collected on 02/22/23 revealed total iron was 27 mcg/dl (A normal range for total iron is 45 to 160 mcg/dl). Interview with Resident #3's primary care provider (PCP) on 03/15/23 at 4:07pm revealed: -Resident #3 was prescribed ferrous sulfate for iron deficiency anemia (insufficient iron in the blood stream). -Missing 6 consecutive doses of ferrous sulfate could worsen Resident #3's anemia which could cause shortness of breath.	D 358		