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 _____	R 04/06/2023

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 conducted an annual and follow-up survey from 04/05/23 through 04/06/23.	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 ensure medications were administered as ordered for 2 of 4 residents (#6,#7) observed during the medication pass including errors with medications used to treat high blood pressure, dementia (#6) and constipation (#7). The findings are: The medication error rate was 9% as evidenced by 3 errors out of 31 opportunities during the 8:00am morning medication pass on 04/05/23. 1. Review of Resident #6's current FL-2 dated 03/28/23 revealed diagnoses included hypertension and dementia. a. Review of Resident #6's current FL-2 dated 03/28/23 revealed there was a physician's order for Coreg 3.125mg to be administered daily.	D 358		

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D 358	Continued From page 1 (Coreg is a medication used to treat high blood pressure.) Observation of the 8:00am medication pass on 04/05/23 revealed: -The medication aide (MA) prepared 5 oral medications for administration to Resident #6. -The MA administered 5 oral medications and documented administration on the electronic Medication administration record (eMAR) after watching the resident take the medications. -Coreg 3.125mg was not administered to Resident #6. Review of Resident #6's eMAR for April 2023 revealed: -There was an electronic entry for Coreg 3.125mg to be administered each day and scheduled for 8:00am. -There was documentation Coreg 3.125mg was administered on 04/05/23 at 8:00am. Telephone interview with Resident #6's primary care provider on 04/06/23 at 11:03am revealed: -Coreg 3.125mg was ordered for Resident #6 because of a history of atrial fibrillation. -Attempts to obtain additional information was unsuccessful. Telephone interview with the facility's contracted pharmacy on 04/06/23 at 12:42pm revealed missing a single dose of Coreg or administration of doses with less than 24 hours in between was not a real concern but medication should be administered as prescribed. Interview with the MA on 04/05/23 at 12:37pm revealed: -She thought she pulled and administered Coreg 3.125 to Resident #6.	D 358		

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D 358	Continued From page 2	D 358		

-She was nervous being observed administering medications and it was human error that she administered another medication instead.

b. Review of Resident #6's current FL-2 dated 03/28/23 revealed there was a physician's order for donepezil HCL 10mg to be administered every evening. (Donepezil is a medication used to treat dementia.)

Observation of the 8:00am medication pass on 04/05/23 revealed:
-The morning medication aide (MA) prepared 5 oral medications for administration to Resident #6 which included donepezil 10mg.
-The MA administered 5 oral medications and documented administration on the electronic Medication administration record (eMAR) after watching Resident #6 take the medications.
-Donepezil 10mg was administered to Resident #6.

Review of Resident #6's eMAR for April 2023 revealed:
-There was an electronic entry for donepezil 10mg to be administered every evening and scheduled for administration at 8:00pm.
-There was no documentation donepezil 10mg was administered on 04/05/23.

Telephone interview with the facility's contracted pharmacy on 04/06/23 at 12:42pm revealed donepezil was prescribed to slow the progression of dementia and could be administered morning or evening.

Attempted telephone interview with Resident #6's primary care provider on 04/06/23 at 11:03am revealed no information was given regarding donepezil.

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D 358	Continued From page 3 Interview with the MA on 04/05/23 at 12:37pm revealed she was nervous being observed administering medications and it was human error that she thought she was administering a different medication. Refer to second interview with the HWD on 04/06/23 at 1:55pm. Refer to interview with the Administrator on 04/06/23 at 1:23pm. 2. Review of Resident #7's current FL-2 dated 09/28/23 revealed diagnoses included dementia, iron deficiency anemia, high cholesterol and impaired mobility. Review of Resident #7's physician's order dated 10/03/23 revealed daily fiber capsule was to be administered each day 2 hours before or after a meal. (Daily fiber capsule is used to supplement dietary fiber to ensure regular bowel movements, treat constipation and help lower cholesterol.) Observation of the 8:00am medication pass on 04/05/23 revealed: -The medication aide (MA) prepared 8 oral medications for administration to Resident #7. -The MA administered 8 medications and documented administration on the eMAR after watching Resident #7 take the medication. -Resident #7's breakfast tray was delivered to her room and placed on the tray table beside her as medications were administered to her. -Resident #7 was observed to begin eating breakfast after taking her medications. Review of Resident #7's eMAR April 2023 revealed:	D 358		

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D 358	Continued From page 4 -There was a computerized entry for daily fiber capsule to be administered each day and was scheduled for administration at 8:00am. -There was documentation daily fiber capsule was administered on 04/06/23. Interview with Resident #7's hospice nurse on 04/06/23 at 10:50am revealed daily fiber capsule could prevent constipation caused by the iron supplement prescribed for anemia but constipation was not currently a problem for Resident #7. Telephone interview with the facility's contracted pharmacy on 04/06/23 at 12:42pm revealed taking the fiber capsule with a meal did not change the effectiveness of the medication. Interview with the MA on 04/05/23 at 12:37pm revealed: -Breakfast was served to the residents at 8:00am each day. -She always administered Resident #7's daily fiber capsule during the 8:00am medication administration pass. -She never noticed the instructions for administration 2 hours before or after a meal. Interview with the Health and Wellness Director (HWD) on 04/05/23 at 1:00pm revealed: -She thought she entered the time of the daily fiber capsule on the eMAR and should have scheduled administration for 6:00am. -She did not remember that the medication order contained instructions to administer 2 hours before or after a meal. Attempted interview with Resident #7's primary care provider on 04/06/23 at 10:25am was unsuccessful.	D 358		

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D 358	Continued From page 5 Refer to second interview with the HWD on 04/06/23 at 1:55pm. Refer to interview with the Administrator on 04/06/23 at 1:23pm. _____ Second interview with the HWD on 04/06/23 at 1:55pm revealed: -She conducted MA training for employees at the facility. -She taught the MAs to do three checks at the time a medication was administered including reading the eMAR and medication label including instructions to ensure medications are administered as ordered. Interview with the Administrator on 04/06/23 at 1:23pm reveled: -She expected MAs to do 3 checks to ensure the "5 rights" of medication administration. (i.e. right medication, right dose, right route, right time, right resident) -She expected MAs to read the order on the eMAR, including any instructions, and administer medications as prescribed by the provider. -MAs could enter administration times on the eMAR but the HWD was responsible for ensuring orders were on the eMAR and timed appropriately when new orders were received.	D 358		