STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064004	A. BUILDING: _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREKENRIDGE RETIREMENT CENTER	2500 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 from 02/28/24 to 02/29/24.	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 observation, interview and record review the facility failed to administered medications as ordered for 1 of 5 sampled residents including a medication used to prevent fluid overload (#1). The findings are: Review of Resident #1's current FL-2 dated 10/26/23 revealed: -Diagnoses included chronic respiratory failure, renal insufficiency and chronic diastolic heart failure. -There was an order for daily weights and to give metolazone for weight gain greater than 3 lbs in 24 hours or 5 lbs in a week. -There was an order for metolazone 5mg to be administered as needed for a weight gain greater than 3 lbs in 24 hours or 5 lbs in a week. (Metolazone is a diuretic medication used to treat fluid retention caused by congestive heart failure and/or kidney disease.)	D 358	A quick reference log was created, Residents with Daily Weights and Intervention" to log daily weights and if the resident is to receive their PRN medication as it relates to their weight. This log is reviewed every Wednesday by the Facility RN and will address any concerns. In-service on Rule Area 13F .1004 Medication Administration and the new Quick Reference Tool with all Medication Techs and Supervisors Monthly Cart Audits are completed by an RN to compare available medications on the med cart to the MAR. RN will submit findings to the Facility RN to review or make any changes. Daily Orders are reviewed by the SIC/MT by what the Pharmacy enters for efficiency. Daily Double Medication Check In from the Pharmacy to ensure the Medication is Correctly delivered. Medication received is Compared to what is currently on the Med Cart.	3/1/2024 3/1/2024 3/1/2024

Reviewed and Acknowledged 5/6/2024 SC

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D 358	Continued From page 1 Review of Resident #1's physician's order dated 12/05/23 revealed metolazone 5mg was to be administered 1 hour before scheduled Lasix as needed for weight gain greater than 3 lbs in 24 hours or 5 lbs in a week and to be sure to obtain weight first thing in the morning prior to administering scheduled medications. (Lasix is a medication used to treat fluid retention.) Observation of medications on hand for Resident #1 on 02/29/24 to 8:44am revealed: -There was a dispensing card labeled for metolazone 5mg to be administered one hour before scheduled Lasix daily as needed for weight gain greater than 3 lbs in 24 hours or 5 lbs in a week. -A quantity of 30 tablets was dispensed n 12/05/23 and there were 28 doses remaining. Review of Resident #1 electronic treatment administration record (TAR) for January 2024 revealed: -There was documentation daily weights were obtained on 01/02/24 through 01/06/24 and on 01/19/24 through 01/31/24. -There was documentation Resident #1 weighed 147 lbs on 01/21/24 and 150.2 lbs on 01/22/24 for a weight gain of 3.2 lbs in 24 hours. -There was documentation daily weights were not obtained on 01/01/24, 01/07/24 and on 01/17/24 through 01/18/24 because Resident #1 refused. -There was documentation daily weights were not obtained on 01/08/24 through 01/16/24 because she was in the hospital. Review of Resident #1's electronic medication administration record (eMAR) for January 2024 revealed: -There was a computerized entry for metolazone	D 358		

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D 358	Continued From page 2 5mg to be administered one hour before scheduled Lasix daily as needed for weight gain greater than 3 lbs in 24 hours or 5 lbs in a week. -There no documentation metolazone 5mg was administered from 01/01/24 thought 01/31/24. Review of Resident #1's TAR for February 2024 revealed: -There was documentation daily weights were obtained on 02/01/24 through 02/02/24, 02/04/24 through 02/23/24 and on 02/25/24 thought 02/28/24. -There was documentation Resident #1 weighed 142.6 lbs on 02/05/24 and 148.6 lbs on 02/06/24 for a weight gain of 6 lbs in 24 hours. -There was documentation Resident #1 weighed 143.8 lbs on 02/22/24 and 148.2 lbs on 02/23/24 for a weight gain of 4.4 lbs in 24 hours. -There was documentation daily weights were not obtained on 02/03/24 because Resident #1 refused. -There was documentation daily weights were not obtained on 02/24/24 and there was to documentation as to why the weight was not obtained. Review of Resident #1's MAR for February 2024 revealed: -There was a computerized entry for metolazone 5mg to be administered one hour before scheduled Lasix daily as needed for weight gain greater than 3 lbs in 24 hours or 5 lbs in a week. -There no documentation metolazone 5mg was administered from 02/01/24 thought 02/28/24. Review of a notification to provider note dated 02/29/24 at 9:18am revealed: -Resident #1 weighed 143.8 on 02/22/24 and on 02/23/24 she weighed 148.2 and metolazone was not administered.	D 358		

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D 358	Continued From page 3 -Resident #1's current weight was 150.2 on 02/29/24. -Resident #1's weight was unknown on 02/24/24, 149.8 lbs on 02/25/24, 148.8 lbs on 02/26/24 and 149.2 lbs on 02/28/24. -Resident weighed 147.6 lbs on 02/05/24 and 148.6 lbs on 02/06/24 and the metolazone was not administered. -There was a response from Resident #1's primary care provider (PCP) with instructions to administer the metolazone 5mg, continue the current metolazone and to monitor Resident #1 for shortness of breath, dyspnea on exertion, chest pain and peripheral edema and to notify the provider which was dated 02/29/24. Telephone interview with the pharmacist for Resident #1's pharmacy on 02/29/24 at 9:06am revealed: -Metolazone with a fast acting diuretic medication used to remove fluid quickly from the system. -Fluid could build up quickly in the body when a person's kidneys aren't as effective at removing fluid. -The extra fluid causes the heart to work harder and lead to heart failure. -Not receiving the medication could cause shortness of breath and fluid could back up into the lungs. Telephone interview with the registered nurse (RN) for Resident #1's primary care provider on 02/29/24 at 10:15am revealed: -Resident #1 was prescribed metolazone to prevent excess fluid from building up around her heart. -Not receiving the metolazone 5mg as prescribed could increase the strain on the heart and cause shortness of breath and chest pain.	D 358		

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D 358	Continued From page 4 Interview with the medication aide (MA) on 02/29/24 at 8:48am revealed: -Resident #1 was weighed daily before breakfast to monitor for fluid retention which could lead to difficulty breathing. -Resident #1 weighed 150.2 lbs that morning (02/29/24). (This is a 6.4 lbs weight gain from 02/22/24.) -Resident #1 was to receive metolazone 5mg one hour before scheduled Lasix daily as needed for weight gain greater than 3 lbs in 24 hours or 5 lbs in a week. -She looked back over the previous 2-3 days weights each morning. -She did not administer metolazone 5mg on 02/29/24 and she did not remember ever having to administer the medication. -She did not realize Resident #1 had gained 6.4 lbs in the last week and she should have looked back over the last 7 days for with gain. -She did not realize Resident #1 had gained 4.4 lbs in 24 hours on 02/23/24 and she did not administer the metolazone 5mg as ordered. Interview with the Administrator on 02/29/24 at 10:30am revealed: -Medications should be administered as ordered. -The Director of Nursing (DON) was responsible for audits of the eMAR and ensuring all orders were followed. Interview with the Director of Nursing (DON) on 02/29/24 at 9:41am revealed: -MAs were responsible for obtaining daily weights for Resident #1. -MAs should look back over the previous 7 days to determine weight gain each day. -The daily weights were on the TAR and MAs had to go into the system to pull them up for review. -There was a short cheat sheet for MA's to	D 358		

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D 358	Continued From page 5 document daily weights on to make the review of weights easier than going into the system but they were not done consistently. -She conducted audits quarterly of the weights to ensure they were completed and the metolazone was administered appropriately and the last audit was completed in January 2024. -She did not know the metolazone 5mg was not administered to Resident #1 per the ordered parameters.	D 358		