Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 on 04/19/22 to 04/21/22.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 3 of 7 sampled residents including a steroid medication (#2), sliding scale insulin orders (#5) and a steroid inhaler (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 02/17/22 revealed: -Diagnoses included acute and chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). -There was an order for Prednisone 10mg one tablet every day. (Prednisone is a steroid	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 344	Continued From page 1 medication used to decrease inflammation.) Review of Resident #2's physician's orders dated 03/07/22 revealed there was an order for Prednisone 40mg for 5 days, then continue regular dose of Prednisone. Review of Resident #2's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Prednisone 10mg one time a day to be administered at 8am. -The Prednisone 10mg was documented as administered every day except 03/16/22-03/23/22 which was noted that the resident was in the hospital and on 03/30/22-03/31/22 which was noted that the medication was on hold. -There was an entry for Prednisone 40mg one time a day to be started on 03/10/22 and administered at 8:00am. -The Prednisone 40mg was documented as administered on 03/10/22 and 03/11/22. Interview with the facility's Health and Wellness Director (HWD) on 04/21/22 at 1:16pm revealed: -The physician order for Prednisone 40mg dated 03/07/22 was unclear about whether the Prednisone 10mg and the Prednisone 40mg should have been given at the same time. -A medication aide (MA) should have contacted Resident #2's primary care provider (PCP) to clarify the Prednisone 40mg order. -Resident #2 could have received too high of a dose of Prednisone since he was receiving two different doses of the same medication at the same time. Telephone interview with Resident #2's PCP on 04/21/22 at 11:16am revealed: -She ordered Prednisone 40mg on 03/07/22	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 344	Continued From page 2 because Resident #2 had an exacerbation of his COPD. -Resident #2 should not have received Prednisone 40mg and Prednisone 10mg at the same time. -The facility should have stopped giving Resident #2 the Prednisone 10mg while he was receiving the Prednisone 40mg. -Facility staff should have clarified the Prednisone 40mg order with her if they felt the order was unclear. 2. Review of Resident #5's current FL-2 dated 03/17/22 revealed: -Diagnoses included type 2 diabetes mellitus. -There was an order for Novolin R Insulin Solution 100units/mL inject per sliding scale (Novolin R is a fast-acting insulin used to treat diabetes). Review of Resident #5's physician orders dated 01/27/21 revealed there was an order for Novolin R Insulin Solution inject as per sliding scale: if blood sugar 150-200 give 3 units, 201-250 give 6 units, 251-300 give 9 units, 301-350 give 12 units, 351-400 give 15 units, if greater than 400 notify provider, subcutaneously two times a day. Review of Resident #5's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Novolin R Insulin Solution 100units/mL with instructions to inject per sliding scale if blood sugar 150-200 give 3 units, 201-250 give 6 units, 251-300 give 9 units, 301-350 give 12 units, 351-400 give 15 units, if greater than 400 notify provider, before meals and at bedtime. -Novolin R Insulin Solution 100units/mL was scheduled for administration at 7:00am, 11:00am,	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 344	Continued From page 3 4:00pm, and 8:00pm, and documented as administered from 04/01/22 to 04/19/22. Review of Resident #5's April 2022 eMAR revealed: -There was an entry for Novolin R Insulin Solution 100units/mL with instructions to inject per sliding scale if blood sugar 150-200 give 3 units, 201-250 give 6 units, 251-300 give 9 units, 301-350 give 12 units, 351-400 give 15 units, if greater than 400 notify provider, before meals and at bedtime. -Novolin R Insulin Solution 100units/mL was scheduled for administration at 7:00am, 11:00am, 4:00pm, and 8:00pm, and documented as administered from 03/01/22 to 03/31/22. Interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 9:00am revealed: -It was her responsibility to copy FL-2's yearly and have the resident's primary care provider (PCP) sign the new FL-2. -She should have written out Resident #5's sliding scale instead of noting on the FL-2 "per sliding scale". -She recently became responsible for renewing FL-2 as part of her position since the facility hired a second HWC, within the last couple of weeks. -There was no one that checked behind her to ensure that the FL-2s were correctly transcribed expect the PCP who signed the document. -The facility did not have a standing sliding scale order. Interview with the Health and Wellness Director (HWD) on 04/20/22 at 2:35pm revealed: -It was the responsibility of the HWC to complete yearly FL-2. -She expected the HWC to write out the sliding	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 344	Continued From page 4 scale instructions for Resident #5 rather than say "per sliding scale". -The HWC entered the information onto the eMAR from the FL-2 or physician orders. -There was no audit process in place to ensure that FL-2 orders are correctly entered by the HWC. -She would reach out to Resident #5's PCP to clarify Resident #5's "per sliding scale" order on her FL-2. -FL-2 and physician's orders did not get faxed to the pharmacy unless there was a change in medications. Interview with Resident #5's primary care provider (PCP) on 04/21/22 at 9:30am revealed: -She did not realize that Resident #5's FL-2 said "per sliding scale" when she signed it. -There were no medication changes on Resident #5's FL-2 signed 03/17/22. -The facility contacted her yesterday (04/20/21) to clarify Resident #5's Novolin R sliding scale dose. 3. Review of Resident #3's current FL-2 dated 02/24/22 revealed: -Diagnoses incluced chronic obstructive pulmonary disease (COPD). -There was an order for Trelegy Ellipta inhaler 100-62.5-25, inhale 1 puff once a day (Trelegy Ellipta is a medication used to treat COPD). -There was no order for Spiriva inhaler (Spiriva is a medication used to treat COPD). -The FL-2 was signed by the hospitalist that discharged Resident #3 from the hospital. Review of Resident #3's hospitalization discharge summary on 02/24/22 revealed she should stop taking Spiriva inhaler and begin taking Trelegy Ellipta inhaler.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 344	Continued From page 5 Review of Resident #3's facility record revealed: -There was a form from the pharmacy asking for clarification after her hospitalization related to the Spiriva inhaler and whether the resident was to continue the Spiriva while taking the Trelegy Ellipta. -The form was not signed or faxed to Resident #3's primary care provider (PCP). Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Spiriva 2.5mcg with instructions to inhale one 2 puffs one time a day, scheduled for administration at 8:00am. -Spiriva 2.5mcg was documented as administered on 02/25/22 and 02/28/22 at 8:00am. -Spiriva 2.5mcg was documented as not given due to waiting on pharmacy to send the medication on 02/26/22 and 02/27/22. Review of Resident #3's March 2022 eMAR revealed: -There was an entry for Spiriva 2.5mcg with instructions to inhale one 2 puffs one time a day, scheduled for administration at 8:00am. -Spiriva 2.5mcg was documented as administered from 03/01/22 to 03/31/22 at 8:00am. Review of Resident #3's April 2022 eMAR from 04/01/22 to 04/20/22 revealed: -There was an entry for Spiriva 2.5mcg with instructions to inhale one 2 puffs one time a day, scheduled for administration at 8:00am. -Spiriva 2.5mcg was documented as administered from 04/01/22 to 04/20/22. Review of Resident #3's physician orders dated	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 344	Continued From page 6 01/18/22 revealed there was an order for Spiriva 2.5mcg, 2 inhalations once a day. Interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 9:00am revealed: -When a resident returned from the hospital it was the medication aide (MA) that was working when the resident returned from the facility's responsibility to enter any new medication orders. -The hospital sent Resident #3's Trelegy Ellipta inhaler prescription directly to the pharmacy to be filled. -The pharmacy clarification sheet was sent to the facility from the pharmacy when Resident #3 returned from the hospital with medication changes. -It was the facilities responsibility, she was not sure who specifically, to get clarification from the resident's physician whether or not they wanted to the resident to continue to get the medication listed on the sheet. Interview with the Health and Wellness Director (HWD) on 04/20/22 at 2:35pm revealed: -She was not aware that there was an order to discontinue Spiriva after Resident #3's 02/24/22 hospitalization. -The pharmacy clarification form sent by the pharmacy after Resident #3's hospitalization should have been clarified by Resident #3's PCP. -It was the responsibility of the HWC to ensure that medication orders were clarified as needed upon residents returning from hospitalization. Attempted telephone interview with Resident #3's PCP on 04/21/22 at 10:55am and 12:45pm were unsuccessful.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 7	D 358		
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 3 of 3 residents (#3, #5, #7) during the morning medication pass including errors involving insulin administration (#5), medications used to treat constipation (#7) and medications used to treat chronic obstructive pulmonary disease (#3), and for 1 of 7 residents sampled for record review including errors involving insulin administration (#5). The findings are: 1. The medication error rate was 17% as evidenced by the observation of 5 errors with 28 opportunities during the morning medication pass on 04/20/22. a. Review of Resident #5's current FL-2 dated 03/17/22 revealed diagnoses included type 2 diabetes mellitus. Observation of the morning medication pass on 04/20/22 revealed: -Resident #5's fingerstick blood sugar was 155 at 7:43am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 8 -The medication aide (MA) administered 3 units of Novolin R insulin to Resident #3 in her abdomen at 7:46am (Novolin R is a fast-acting insulin used to lower blood sugar). -The MA did not prime the insulin pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing through the needle so that the resident received the full dose of insulin. Review of the manufacturer's prescribing information for Novolin R insulin pen revealed: -After the needle was attached, a safety test should have been performed. -The safety test is performed by dialing a test dose of 2 units and pressing the injection button and check to see that insulin comes out of the needle. Review of Resident #5's physician orders dated 04/20/22 revealed there was an order for Novolin R insulin inject subcutaneously before meals and at bedtime as per sliding scale for blood sugar results of 150-200 give 3 units; 201-250 give 6 units; 251-300 give 9 units; 301-350 give 12 units; 351-400 give 15 units; if greater than 400 notify provider. Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Novolin R insulin inject subcutaneously before meals and at bedtime as per sliding scale for blood sugar results of 150-200 give 3 units; 201-250 give 6 units; 251-300 give 9 units; 301-350 give 12 units; 351-400 give 15 units; if greater than 400 notify provider, scheduled for administration at 7:00am, 11:00am, 4:00pm, and 8:00pm. -Novolin R Insulin 3 units was documented as	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 9 administered on 04/20/22 at 7:00am. Interview with the MA on 04/20/22 at 10:45am revealed: -She was trained to prime the insulin pens with two units prior to dialing the resident's ordered dose for administration. -She was "thrown off" this morning (04/20/22) because Resident #5's blood sugar was not normally high enough in the morning for her to receive insulin. -It was important to prime the insulin pens prior to use so that the resident received all of the ordered insulin. Interview with the Health and Wellness Coordinator on 04/21/22 at 9:00am revealed MAs were trained to prime the insulin pens prior to dialing the ordered amount so that the resident received all of the ordered insulin. Interview with the Health and Wellness Director on 04/20/22 at 11:50am revealed it was the responsibility of the MA to ensure that Resident #5 received her ordered insulin per the manufacturer's guidelines, including priming the needle. Interview with Resident #5's primary care provider (PCP) on 04/21/22 at 9:30am revealed: -She expected MAs to administer medications per the manufacturers guidelines which included priming the insulin pen for Novolin injections. -If a resident didn't receive the full dose of medication, that could result in Resident #5's blood sugar being elevated which included symptoms such as fatigue, nausea, vomiting, and increased thirst. b. Review of Resident #7's current FL-2 dated	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 12/08/20 revealed diagnoses included chronic constipation and anxiety. Review of Resident #7's physician's orders dated 04/06/22 revealed there was an order for Miralax 17gm once daily (Miralax is a laxative used to treat constipation). Observation of the morning medication pass on 04/20/22 revealed: -The medication aide (MA) handed Resident #7 her Miralax mixed in an 8-ounce cup of water at 8:12am. -Resident #7 used ¾ of the cup of Miralax to swallow her pills from 8:13am until 8:16am. -She then took two puffs of an inhaler medication at 8:18am and began drinking the Miralax to "swish out her mouth" and spit it back into the cup. -The MA discarded the liquid that was spit back into the cup into the trash can. -Resident #7 did not receive the full dose of the Miralax. Interview with Resident #7 at 04/20/22 at 8:57am revealed she didn't like to take her Miralax in water and she normally took the Miralax powder down to the dining room to drink it with her orange juice which is why she spit out the water. Interview with the MA on 04/20/22 at 11:36am revealed: -She was not sure what to do with the Miralax when the resident spit it back in the cup, but she figured it was not a big deal because she drank most of the dose. -She did not mix Resident #7's Miralax in orange juice because she wasn't aware that Resident #7 would only take the Miralax with orange juice. -When the resident told her that she wanted the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 Miralax in orange juice and not water, the resident had already started to drink the Miralax in water so she was trying to get her to finish drinking the water. Interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 9:00am revealed she expected the MA to ensure that Resident #7 received her full dose of Miralax or notify the HWC so that she could notify the provider. Telephone interview with Resident #7's primary care provider (PCP) on 04/21/22 at 8:30am revealed she expected Resident #7 to receive the full dose of Miralax to prevent any issues with constipation. c. Review of Resident #7's physician orders dated 04/06/22 revealed there was an order for Advair Diskus 250-50 mcg/dose, 1 inhalation every 12 hours with instructions to rinse mouth after each use (Advair is a medication used to treat asthma and shortness of breath). Observation of the morning medication pass on 04/20/22 at 8:20am revealed: -The medication aide (MA) primed the resident's Advair Diskus and the resident took one inhalation at 8:19am. -The resident requested a second puff and the MA primed the Advair Diskus a second time and the resident took a second inhalation at 8:20am. Review of Resident #7's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Advair Diskus 250-50 mcg/dose, 1 inhalation every 12 hours with instructions to rinse mouth after each use.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 scheduled for administration at 8:00am and 8:00pm. -Advair Diskus was documented as administered on 04/20/22 at 8:00am. Interview with the MA on 04/20/22 at 11:36am revealed: -Resident #7 could be difficult to administer medications to because she doesn't always trust that you primed the medication correctly. -Resident #7 requested an additional dose of Advair Diskus and she should have told the resident that she needed to call the doctor before administering the dose. Interview with the Resident Care Director on 04/20/22 at 11:50am revealed she expected the MA to administer only one inhalation of the Advair Diskus to Resident #7 to prevent her from receiving to much medication. Telephone interview with Resident #7's primary care provider (PCP) on 04/21/22 at 8:30am revealed: -She expected Resident #7 to receive the Advair inhaler as ordered, which was one inhalation daily. -Overuse of Advair could cause the resident to have thrush in her mouth or throat. d. Review of Resident #3's current FL-2 dated 02/24/22 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD). -There was no order for Spiriva inhaler (Spiriva is a medication used to treat COPD). Review of Resident #3's hospitalization discharge summary dated 02/24/22 revealed she should stop taking Spiriva inhaler and begin taking	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 Trelegy Ellipta inhaler. Observation of the morning medication pass on 04/20/22 revealed: -The medication aide (MA) handed Resident #3 the Spiriva inhaler. -Resident #3 took one puff of the Spiriva inhaler at 8:35am. -The MA did not provide instruction to Resident #3 about how many puffs to take. Review of Resident #3's April 2022 electronic medication administration record (eMAR) from 04/01/22 to 04/20/22 revealed: -There was an entry for Spiriva 2.5mcg with instructions to inhale 2 puffs one time a day, scheduled for administration at 0800. -Spiriva 2.5mcg was documented as administered on 04/20/22 at 8:00am. Interview with the MA on 04/20/22 at 11:36am revealed: -She should have checked the eMAR to see how many inhalations Resident #3 was to receive from her Spiriva inhaler. -She thought that Resident #3 knew how many inhalations she should get. Interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 9:00am revealed she expected staff to review the eMAR and label on the medication packaging before administering the medication to the residents. Attempted telephone interview with Resident #3's primary care provider (PCP) on 04/21/22 at 10:55am and 12:45pm were unsuccessful. Based on observation and interviews, it was determined that Resident #3 was not	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 interviewable. e. Review of Resident #3's current FL-2 dated 02/24/22 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD). -There was an order for Trelegy Ellipta inhaler 100-62.5-25, inhale 1 puff once a day (Trelegy Ellipta is a medication used to treat COPD). Observation of the morning medication pass on 04/20/22 revealed: -The medication aide (MA) handed Resident #3 the Trelegy Ellipta inhaler to use. -The resident inhaled the Trelegy Ellipta inhaler at 8:38am. -The resident did not rinse her mouth out after using the inhaler. -The MA did not instruct the resident to rinse out her mouth. Review of the Trelegy website for patient instructions revealed there was a warning that oropharyngeal Candidiasis could occur so patients should be instructed to rinse his/her mouth out with water and do not swallow to minimize risk of infection. (oropharyngeal candidiasis is a fungal infection of the mouth.) Review of Resident #3's April electronic medication administration record (eMAR) revealed: -There was an entry for Trelegy Ellipta inhaler 100-62.5-25, inhale 1 puff once a day with instructions to rinse mouth with water after use, scheduled for administration at 8:00am. -Trelegy Ellipta inhaler 100-62.5-25 was documented as administered on 04/20/22 at 8:00am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 15 Observation of Resident #3's medications on hand on 04/21/22 at 12:00pm revealed the medication label on the Trelegy Ellipta inhaler had instructions to rise mouth out with water after use. Interview with the MA on 04/20/22 at 11:36am revealed: -She did not notice the order instructions on the Trelegy Ellipta that instructed the resident to rinse out her mouth with water after use. -She should have looked at the eMAR notes and label packaging to ensure that she was administering the medication properly. Interview with the Health and Wellness Director on 04/21/22 at 11 20am revealed that she expected staff to follow the instructions on the medication order including the instructions for Resident #3's Trelegy Ellipta inhaler to rinse her mouth out after use. Attempted telephone interview with Resident #3's primary care provider (PCP) on 04/21/22 at 10:55am and 12:45pm were unsuccessful. Based on observation and interviews, it was determined that Resident #3 was not interviewable. 2. Review of Resident #5's current FL-2 dated 03/17/22 revealed diagnoses included type 2 diabetes mellitus. Review of Resident #5's physician orders dated 04/20/22 revealed there was an order for Novolin R insulin inject subcutaneously before meals and at bedtime as per sliding scale for blood sugar results of 150-200 give 3 units; 201-250 give 6 units; 251-300 give 9 units; 301-350 give 12 units; 351-400 give 15 units; if greater than 400 notify	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 16 provider. Review of Resident #5's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Novolin R insulin inject subcutaneously before meals and at bedtime as per sliding scale for blood sugar results of 150-200 give 3 units; 201-250 give 6 units; 251-300 give 9 units; 301-350 give 12 units; 351-400 give 15 units; if greater than 400 notify provider, scheduled for administration at 7:00am, 11:00am, 4:00pm, and 8:00pm. -On 02/16/22 at 7:00am was documented as 180 which required 3 units of Novolin R to be administered; zero units were documented as administered. Review of Resident #5's March 2022 eMAR revealed: -There was an entry for Novolin R insulin inject subcutaneously before meals and at bedtime as per sliding scale for blood sugar results of 150-200 give 3 units; 201-250 give 6 units; 251-300 give 9 units; 301-350 give 12 units; 351-400 give 15 units; if greater than 400 notify provider, scheduled for administration at 7:00am, 11:00am, 4:00pm, and 8:00pm. -On 03/10/22 at 7:00am was documented as 161 which required 3 units of Novolin R to be administered; zero units were documented as administered. -Resident #5's blood sugar on 03/10/22 at 11:00am was documented as 263. Interview with the Health and Wellness Director on 04/21/22 at 9:30am revealed: -MAs should refer to the sliding scale insulin order to determine how much insulin to administer to Resident #5.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 17 -If Resident #5 did not receive the amount of insulin ordered the MA should notify the primary care provider (PCP) and document the reason why the medication was not administered. Interview with Resident #5's PCP on 04/21/22 at 9:30am revealed: -She expected Resident #5 to receive her sliding scale insulin as ordered. -If Resident #5 did not receive her insulin as ordered, it may cause her to experience elevated blood sugars. -She monitored the resident's blood sugars and made adjustments based on what she believed the resident was receiving.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the recording of medication administration occurred immediately following the administration of medications including observations of morning medications left in a resident's room (#5). The findings are:	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 366	Continued From page 18 Review of the facility's policy for Medication and Treatment- General Guidelines for Medication Administration/Assistance dated 04/22 revealed: -Residents should be observed taking the medication followed by the offering of water or other fluids. -Medications should no be left for the resident to consume at a later time. Observation of Resident #5's side table next to the recliner on 04/19/22 at 9:25am revealed there was a medication cup with 10 pills inside the cup. Interview with Resident #5 on 04/19/22 at 9:25am revealed: -The medication aides (MAs) were responsible for bringing her medication. -Sometimes the MAs would bring in her medication and leave it for her on the side table next to her recliner for when she returned from breakfast. Review of Resident #5's current FL-2 dated 03/17/22 revealed: -Diagnoses included mild cognitive impairment. -She was intermittently disoriented. Review of Resident #5's facility record revealed she did not have self-administration orders. Interview with the MA on 04/20/22 at 10:45am revealed: -She did not remember leaving Resident #5's medication on her table yesterday (04/19/22). -She normally watched residents swallow their medications. -It was important to watch resident's swallow their medications to ensure they received them.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 366	Continued From page 19 Interview with the Health and Wellness Director on 04/21/22 at 11:20am revealed: -She was not aware that MAs were not observing residents take their medications. -Unless a resident had self-administration orders, MAs were to observe residents take their medication. -There were no wanderers in the facility that would go into other resident's rooms but it was important that if staff were documenting that medications were administered that they would observe them taking the medication. Interview with Resident #5's primary care provider (PCP) on 04/21/22 at 9:00am revealed: -She was concerned that staff was not observing Resident #5 take her medication. -Resident #5 had mild cognitive impairment which resulted in some forgetfulness and it was important that she received all of her medication timely which was the facility's responsibility.	D 366		
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;	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 367	Continued From page 20 (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 medication administration records were complete and accurate for 2 of 7 residents sampled including a medication used to treat symptoms of dementia (#3), tapering steroid medication (#2), and a resident that was out of the facility for a hospital stay (#3). The findings are: Review of the facility's policy for Medication and Treatment- General Guidelines for Medication Administration/Assistance dated 04/22 revealed: -Trained or licensed associates administering or assisting with medications should document medications administered or assisted with on electronic administration records. -Documentation of medications or treatments administered should occur promptly after the resident has taken the medication. -Associates should sign the paper copy of the medication administration record with their full signature and title and initial each medication administered or follow the eMAR procedure as required. 1. Review of Resident #3's current FL-2 dated 02/24/22 revealed: -Diagnoses included chronic obstructive	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 367	Continued From page 21 pulmonary disease (COPD), lymphedema, and diabetes mellitus. -There was an order for Aricept 5 mg daily at bedtime (Aricept is a medication used to treat symptoms of dementia). Observation of the morning medication pass on 04/20/22 from 8:34am to 8:40am revealed: -The medication aide (MA) removed the blister package of Aricept from the medication cart for Resident #3. -She held Resident #3's Aricept 5mg because the eMAR said to administer at 8:00am but the medication package label stated to give at bedtime. -She was going to clarify with the nurse before she gave Resident #3 any Aricept. -She did not administer Aricept 5mg at 8:40am. Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Aricept 5mg with instructions to give one tablet once a daily, scheduled for administration at 8:00am. -Aricept 5mg was documented as administered on 04/20/22 at 8:00am. Interview with the medication aide (MA) on 04/20/22 at 11:36am revealed: -She was busy and did not get a chance to clarify whether or not Resident #3's Aricept order was to be given in the morning, as the eMAR stated, or at bedtime as the package stated. -She should have charted not administered on the eMAR and typed in a comment but was running behind this morning and did not document correctly. Refer to the interview with the Health and	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 367	Continued From page 22 Wellness Coordinator on 04/21/22 at 9:00am. Refer to the interview with the Health and Wellness Director on 04/20/22 at 11:50am. Refer to the interview with a facility contracted primary care provider (PCP) on 04/21/22 at 9:30am. 2. Review of Resident #2's current FL-2 dated 02/17/22 revealed diagnoses included acute and chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). Review of Resident #2's record revealed: -There was a copy of a prescription dated 03/23/22 for Prednisone 10mg take 5 pills for 2 days, then take 4 pills for 2 days, then take 3 pills for 2 days, then take 2 pills for 2 days, then take 1 pill for 2 days. (Prednisone is a steroid medication used to decrease inflammation.) -The prescription was written to dispense 30 tablets. Interview with a pharmacist at the facility's contracted pharmacy on 04/21/22 at 11:36am revealed 30 tablets of Prednisone 10mg were dispensed for Resident #2. Review of Resident #2's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Prednisone 10mg 5 tablets once a day. -The Prednisone 10mg 5 tablets was documented as administered on 03/26/22 and 03/27/22. -There was an entry for Prednisone 10mg 4 tablets once a day. -The Prednisone 10mg 4 tablets was	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 367	Continued From page 23 documented as administered on 03/28/22, 03/29/22, and 03/30/22. -There was an entry for Prednisone 10mg 3 tablets once a day. -The Prednisone 10mg 3 tablets was documented as administered on 03/31/22. -There was documentation that a total of 25 tablets of Prednisone 10mg was administered from 03/26/22-03/31/22. Review of Resident #2's April 2022 eMAR revealed: -There was an entry for Prednisone 10mg 3 tablets once a day. -The Prednisone 10mg 3 tablets was documented as administered on 04/01/22. -There was an entry for Prednisone 10mg 2 tablets once a day. -The Prednisone 10mg 2 tablets was documented as administered on 04/02/22 and 04/03/22. -There was an entry for Prednisone 10mg 1 tablet once a day. -The Prednisone 10mg 1 tablet was documented as administered on 04/04/22 and 04/05/22. -There was documentation that a total of 9 tablets of Prednisone 10mg was administered from 04/01/22-04/05/22. Interview with the Health and Wellness Director (HWD) on 04/21/22 at 1:16pm revealed: -When a medication order is received the medication aides (MAs) enter the medication orders onto the eMARs. -The eMAR was then checked for accuracy by the Health and Wellness Coordinator (HWC). -The HWC should check daily for new orders. -The eMAR is then checked for accuracy by the HWD. -She was concerned that Resident #2's eMAR did	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 367	Continued From page 24 not get checked properly for accuracy. -She did not recall ever seeing the entry for Resident #2's new Prednisone order and did not believe it ever came to her for her to check it. Refer to the interview with the Health and Wellness Coordinator on 04/21/22 at 9:00am. Refer to the interview with the Health and Wellness Director on 04/20/22 at 11:50am. Refer to the interview with a facility contracted primary care provider (PCP) on 04/21/22 at 9:30am. 3. Review of Resident #3's current FL-2 dated 02/24/22 revealed diagnoses included chronic obstructive pulmonary disease (COPD), lymphedema, and diabetes mellitus. Review of Resident #3's physician orders signed 01/18/22 revealed: -There was an order for Aricept 5mg daily, scheduled for administration at 8:00am (Aricept is a medication used to treat memory loss). -The was an order for Claritin 10mg daily, scheduled for administration at 8:00am (Claritin is a medication used to treat allergy symptoms). -There was an order for Colace 100mg to be given every Monday/Wednesday/Friday, scheduled for administration at 8:00am (Colace is a medication used to treat constipation). -There was an order for Multivitamin one time a day, scheduled for administration at 8:00am (Multivitamin is used to treat vitamin depletion). -There was an order for Potassium-Chloride 10mEq take one tablet daily, scheduled for administration at 8:00am (Potassium-Chloride is used to treat low potassium levels). -There was an order for Spiriva 2.5mcg, 2	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 367	Continued From page 25 inhalations one time a day, scheduled for administration at 8:00am (Spiriva is used to treat chronic obstructive pulmonary disease). -There was an order for Vitamin D 50mcg one tablet, once a daily scheduled for administration at 8:00am (Vitamin D is used to treat low levels of Vitamin D). -There was an order for Eliquis 5mg give one tablet, twice a day, scheduled for administration at 8:00am and 8:00pm (Eliquis is used medication used to promote thinning of the blood). -There was an order for Tylenol 500mg to be given three times a day, scheduled for administration at 8:00am, 2:00pm, and 8:00pm (Tylenol is a mild pain reliever). Review of Resident #3's physician discharge summary revealed the resident was hospitalized from 02/19/22 through 02/24/22. Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Aricept 5mg daily, scheduled for administration at 8:00am. -Aricept 5mg was documented as administered on 02/21/22 at 8:00am. -The was an entry for Claritin 10mg daily, scheduled for administration at 8:00am. -Claritin 10mg was documented as administered on 02/21/22 at 8:00am. -There was an entry for Colace 100mg to be given every Monday/Wednesday/Friday, scheduled for administration at 8:00am. -Colace 100mg was documented as administered on 02/21/22 at 8:00am. -There was an entry for Multivitamin one time a day, scheduled for administration at 8:00am. -Multivitamin 1 tablet was documented as	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 367	Continued From page 26 administered on 02/21/22 at 8:00am. -There was an entry for Potassium-Chloride 10mEq take one tablet daily, scheduled for administration at 8:00am. -Potassium-Chloride 10mEq was documented as administered on 02/21/22 at 8:00am. -There was an entry for Spiriva 2.5mcg, 2 inhalations one time a day, scheduled for administration at 8:00am. -Spiriva 2.5mcg was documented as administered on 02/21/22 at 8:00am. -There was an entry for Vitamin D 50mcg one tablet, once a daily scheduled for administration at 8:00am. -Vitamin D 50 mcg was documented as administered on 02/21/22 at 8:00am. -There was an entry for Eliquis 5mg give one tablet, twice a day, scheduled for administration at 8:00am and 8:00pm. -Eliquis 5mg was documented as administered on 02/21/22 at 8:00am. -There was an entry for Tylenol 500mg to be given three times a day, scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Tylenol 500mg was documented as administered on 02/21/22 at 8:00am. Attempted telephone interview with Resident #3's PCP on 04/21/22 at 10:55am and 12:45pm were unsuccessful. Refer to the interview with the Health and Wellness Coordinator on 04/21/22 at 9:00am. Refer to the interview with the Health and Wellness Director on 04/20/22 at 11:50am. Interview with the Health and Wellness Coordinator on 04/21/22 at 9:00am revealed: -Electronic medication administration records	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 367	Continued From page 27 (eMAR) should accurately reflect what was given at the time it was documented. -If a resident was out of the facility, refused the medication, or there was a change in dosage the eMAR should accurately reflect that. -It was the responsibility of the medication aides (MA) to document accurately and completely on the eMAR. -There was no audit process in place that she was aware of to review the eMAR documentation. Interview with the Health and Wellness Director on 04/20/22 at 11:50am revealed she expected staff to document accurately and completed on the eMAR. Interview with a facility contracted primary care provider (PCP) on 04/21/22 at 9:30am revealed: -She did not have access to the facility's electronic documentation system, so she expected the eMAR that was printed by the facility and given to her during her onsite visits to be accurate and complete. -She used the eMAR to make changes to treatments and adjust dosing based on what was documented so it was important that it was accurate and correct.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 371	Continued From page 28 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the morning medication pass on 04/20/22 by 1 of 2 medication aides observed who failed to wash or sanitize their hands between administering medication to multiple residents. The findings are: Review of the facility's policy for Medication and Treatment- General Guidelines for Medication Administration/Assistance dated 04/22 revealed: -Trained or licensed associates administering or assisting with medications should use infection control and prevention practices based on the Centers for Disease Control and Prevention (CDC) guidelines for hand hygiene. -Associates should wash their hands or use hand sanitizer prior to medication administration/assistance for each resident. Observation of the morning medication pass on 04/20/22 from 8:00am to 8:50am revealed: -There was hand sanitizer on the medication cart. -The medication aide (MA) returned to the medication cart from administering medications to a resident at 8:05am. -She did not perform hand hygiene using hand sanitizer or soap and water prior to beginning to prepare the next resident's medications at 8:06am. -The MA entered the resident's room to administer medications at 8:09am. -The MA returned to the medication cart from administering medications to the resident at 8:23am. -She did not perform hand hygiene using hand sanitizer or soap and water prior to beginning to	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 371	Continued From page 29 prepare the next resident's medications at 8:25am. -The MA entered the resident's room to administer medications at 8:34am. -The MA returned to the medication cart from administering medications to the resident at 8:49am. -She did not perform hand hygiene using hand sanitizer or soap and water prior to beginning to prepare the next resident's medications at 8:50am. A second observation of the MA performing morning medication pass 04/20/22 from 9:14am to 9:32am revealed: -The MA returned to the medication cart from administering medications to a resident at 9:14am. -She did not perform hand hygiene using hand sanitizer or soap and water prior to beginning to prepare the next resident's medications at 9:16am. -The MA returned to the medication cart from administering medications to a resident at 9:22am. -She did not perform hand hygiene using hand sanitizer or soap and water prior to beginning to prepare the next resident's medications at 9:25am. -The MA returned to the medication cart from administering medications to a resident at 9:29am. -She did not perform hand hygiene using hand sanitizer or soap and water prior to beginning to prepare the next resident's medications at 9:32am. Interview with the MA on 04/20/22 at 11:36am revealed: -She normally would wash her hands with soap	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 371	Continued From page 30 and water before and after administering each resident their medications, but she was thrown off this morning because she was called late to come in which put her behind. -It was important to perform hand hygiene with either hand sanitizer or soap and water between administering medications to reduce the risk of infection. -She was not sure about the facility's handwashing policy because this was only her second shift here and she worked for a staffing agency. Interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 9:00am revealed: -MAs should perform hand hygiene with hand sanitizer or soap and water after administering medications to each resident or if their hands become visibly soiled. -Hand sanitizer was located on each of the 6 medication carts and residents had soap in their rooms at the sink. -It was important for MAs to wash their hands to prevent cross-contamination and reduce the risk of spreading infection. Interview with the Health and Wellness Director (HWD) on 04/20/22 at 11:50am revealed staff were expected to wash their hands with hand sanitizer or soap and water in between administering medications to prevent the spread of infection. Telephone interview with one of the facility's contracted primary care providers (PCP) at 04/21/22 at 8:30am revealed she expected staff to use hand sanitizer or soap and water in between administering medications to the residents to prevent the risk of infection.	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 371	Continued From page 31 Interview with a second facility's contracted PCP on 04/21/22 at 9:30am revealed: -She expected staff to perform hand hygiene between administering medications to the residents. -It was very important to perform hand hygiene and proper infection control prevention especially now during the times of COVID-19.	D 371		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure medications were locked up when not under the direct physical supervision of staff in charge of medication administration including 1 medication cart, a medication used to treat dementia, and a patch used for smoking cessation. The findings are: Review of the facility's policy for Medication and Treatment- Storage dated 10/18 revealed medications and treatments stored by the community are to be stored in designated locations that must be locked when not in use or when unattended.	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 378	Continued From page 32 1. Observation of the medication cart in the hallway between resident room #103 and resident room #104 on 04/19/22 from 8:45am to 9:00am revealed: -The medication cart was unlocked. -There was no staff at the medication cart. -There was a resident and staff member in the hallway at 8:45am walking towards the main entrance. -At 8:50am a resident ambulated down the hallway past the medication cart. -Two staff members passed the medication cart delivering breakfast meals down the hallway at 8:52am. -At 8:56am the two staff members and a resident got on the elevator to the right of the medication cart. -At 9:00am a medication aide (MA) returned to the medication cart, retrieved trash from side of the medication cart, and locked the medication cart. Interview with the MA on 04/19/22 at 9:00am revealed: -She was responsible for passing medications out of the medication cart. -She passed medications out of three carts, two on the first floor and one on the second. -Medication carts should be locked if they were unattended so that no one can go in them but the MAs or nurses. -She was not aware of any residents that opened the medication cart but there were some residents that stood at the cart waiting for their medications. -She was side tracked printing paperwork for a resident to go to a doctor's appointment and must have forgotten to lock the medication cart.	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 378	Continued From page 33 Interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 9:00am revealed: -Medication carts should be locked if the MA was not physically at the medication cart. -If medication carts were not locked, there was a risk for residents to go in the medication cart. -She was not aware of any residents that were known to go through the medication cart. Interview with the Health and Wellness Director (HWD) on 04/20/22 at 11:50am revealed: -She expected staff to lock the medication carts if they were not in use. -She was not aware of any residents that were known to go through the medication cart. Telephone interview with one of the facility's contracted primary care providers (PCP) at 04/21/22 at 8:30am revealed she expected staff to lock the medication carts when not in use to prevent residents, visitors or staff from getting into the medication cart. Interview with a second facility's contracted PCP on 04/21/22 at 9:30am revealed: -She expected the medication carts at the facility to remain locked when not in use. -She had observed on her visits to the facility residents standing at the medication carts. 2. Observation of the medication cart on 04/20/22 at 8:30am to 8:50am revealed: -The medication aide (MA) prepared medication for a resident. -She was unsure about administration of Aricept and wanted to get clarification from the nurse prior to administering the medication (Aricept is a medication used to symptoms of dementia or memory loss).	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 378	Continued From page 34 -At 8:34am she placed the blister package of Aricept on top of the medication cart, locked the cart and entered the resident's room leaving the package unattended. -The blister package of Aricept had 22 pills remaining in the package. -At 8:49am she returned to the cart and placed the Aricept blister package back into the medication cart with the resident's other medications. Interview with the MA on 04/20/22 at 11:36am revealed: -She did not remember leaving the Aricept medication package on top of the medication cart. -All medications should be placed in the medication cart and locked when a staff member is not at the cart. -This was her second day at the facility, but she was not made aware of any residents that may take medications from the cart that were not theirs. -There were residents that came to the medication cart waiting to get their medication. Interview with the Health and Wellness Coordinator (HWC) on 04/21/22 at 9:00am revealed medications should not be left unattended on top of the cart. Interview with the Health and Wellness Director (HWD) on 04/20/22 at 11:50am revealed she expected staff to lock all medications inside the medication cart and never leave any medications unattended on top of the medication cart. 3. Review of Resident #3's current FL-2 dated 08/02/21 revealed diagnoses included obstructive sleep apnea.	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

(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 378	Continued From page 35 Review of Resident #3's physician order dated 03/03/22 revealed an order for Nicotine patch 21mg/24 hours. apply one patch per day (Nicotine patch is used for smoking cessation). Observation of the morning medication pass on 04/20/22 revealed: -Resident #3's Nicotine patch was not on the medication cart when the medication aide (MA) was preparing her morning medication. -The MA located the Nicotine patches in the resident's room in a drawer across from her recliner. Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed there was an entry for Nicotine patch with instructions to apply 1 patch per day and remove per schedule, scheduled for removal at 7:59am and application at 8:00am. Interview with the Health and Wellness Director on 04/20/22 at 10:42am revealed: -She instructed staff yesterday (04/19/22) to ensure that they removed the Nicotine patches from Resident #3's room and placed them on the medication cart. -Resident #3's family member must have brought in additional Nicotine patches last night because she was running low. Attempted telephone interview with Resident #3's family member on 04/21/22 at 9:55am was unsuccessful. Attempted telephone interview with Resident #3's primary care provider (PCP) on 04/21/22 at 10:55am and 12:45pm were unsuccessful.	D 378		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL096026 Y1	A. Building B. Wing Y2	4/21/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0273 Reg. # 10A NCAC 13F .0902(b) LSC	Correction Completed 08/15/2019	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR [signature]	DATE 05/24/22
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/20/2019		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ NO