STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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 on 04/12/22 to 04/13/22.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up to meet the healthcare needs for 2 of 5 sampled residents (#1 and #4) after an unwitnessed fall with a head injury (#4) and for elevated blood sugar levels and delayed insulin administration (#1). The findings are: Review of Resident #1's current FL-2 dated 11/09/21 revealed diagnoses included hyperlipidemia, dementia and type II diabetes mellitus. Review Resident #1's subsequent physician's orders revealed: -A physician's order dated 02/01/22 for insulin Humalog (a fast-acting insulin used to treat hyperglycemia) give insulin according to the following sliding scale subcutaneously (SQ) before meals and at bedtime, for finger stick blood sugar (FSBS) 151-200 give 1 unit; FSBS 201-250 give 2 units; FSBS 251-300 give 5 units;FSBS 301-350 give 8 units; FSBS 351-400 give 11 units; FSBS 401-450 give 14; and FSBS	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

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D 273	Continued From page 1	D 273		

greater than 451 give 16 units and call the PCP.
-An endocrinologist order dated 02/10/22 revealed an order for Humalog insulin according to the following sliding scale SQ before meals and at bedtime, for FSBS less than 200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; and FSBS 351 plus give 4 units.
-A signed physician's order summary report dated 02/22/22 to check FSBS levels four times daily before meals and at bedtime and notify the PCP for results less than 50 or greater than 500.
-A signed physician's order summary report dated 02/22/22 for Humalog insulin according to the following sliding scale SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-450 give 5 units and call endocrinology.

Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed:
-An entry starting 01/30/22 and ending 02/01/22, for Humalog sliding scale coverage SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-500 give 5 units and call endocrinology.
-On 02/01/22 at 7:00am, the FSBS result was documented as 497.
-On 02/01/22 at 11:30am, the FSBS was documented as 572.
-A second entry starting 02/01/22 at 4:00pm and ending 02/15/22, for Humalog sliding scale SQ before meals and at bedtime, for FSBS 151-200 give 1 unit; FSBS 201-250 give 2 units; FSBS 251-300 give 5 units; FSBS 301-350 give 8 units;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

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D 273	Continued From page 2 FSBS 351-400 give 11 units; FSBS 401-450 give 14; FSBS greater than 451 give 16 units and call the PCP. -On 02/04/22 at 11:00am, the FSBS result was documented as 600. -On 02/07/22 at 11:00am, the FSBS result was documented as 600. -On 02/11/22 at 11:00am, the FSBS result was documented as 478. -On 02/13/22 at 11:00am, the FSBS result was documented as 600. -A third entry starting 02/15/22 at 11:00am, for Humalog sliding scale SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-450 give 5 units and call endocrinology. -On 02/17/22 at 11:00am, the FSBS result was documented as 517. -On 02/19/22 at 7:00am, the FSBS result was documented as 467. -On 02/19/22 at 11:00am, the FSBS result was documented as 467. -On 02/19/22 at 4:00pm, the FSBS result was documented as 443. -On 02/19/22 at 8:00pm, the FSBS result was documented as 442. -On 02/20/22 at 11:00am, the FSBS result was documented as 450. -On 02/24/22 at 11:00am, the FSBS result was documented as 600. -On 02/28/22 at 11:00am, the FSBS result was documented as 452. -There was no documentation the endocrinologist was notified the resident's FSBS was greater than 401. Review of Resident #1's February 2022 electronic progress notes revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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 273	Continued From page 3	D 273		

-On 02/17/22 at 12:03pm, 5 units of Humalog insulin was administered, and a physician was notified.
-On 02/24/22 at 12:00pm, 5 units of Humalog insulin was administered, and a physician was notified.
-On 02/24/22 at 3:56pm, FSBS result was "HI", a message was left for Endocrinology.

Review of Resident #1's March 2022 eMAR revealed:
-An entry for Humalog sliding scale SQ coverage before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-450 give 5 units and call endocrinology.
-On 03/01/22 at 7:00am, the FSBS result was documented as 425.
-On 03/03/22 at 11:00am, the FSBS result was documented as 412.
-On 03/04/22 at 7:00am, the FSBS result was documented as 475.
-On 03/04/22 at 11:00am, the FSBS result was documented as 532.
-On 03/04/22 at 4:00pm, the FSBS result was documented as 428.
-On 03/05/22 at 7:00am, the FSBS result was documented as 438.
-On 03/05/22 at 11:00am, the FSBS result was documented as 447.
-On 03/06/22 at 11:00am, the FSBS result was documented as 586.
-On 03/07/22 at 11:00am, the FSBS result was documented as 490.
-On 03/07/22 at 4:00pm, the FSBS result was documented as 405.
-On 03/10/22 at 11:00am, the FSBS result was documented as 443.
-On 458 on 03/13/22 at 11:00am, the FSBS result

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

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D 273	Continued From page 4	D 273		

was documented as 458.
-On 03/17/22 at 4:00pm, the FSBS result was documented as 502.
-On 03/18/22 at 11:00am, the FSBS result was documented as 450.
-On 03/19/22 at 11:00am, the FSBS result was documented as 520.
-On 03/19/22 at 8:00pm, the FSBS result was documented as 529.
-On 03/20/22 at 11:00am, the FSBS result was documented as 468.
-On 03/20/22 at 4:00pm, the FSBS result was documented as 404.
-On 03/21/22 at 11:00am, the FSBS result was documented as 577.
-On 03/21/22 at 11:00am, the FSBS result was documented as 438.
-On 03/22/22 at 11:00am, the FSBS result was documented as 458.
-On 03/25/22 at 11:00am, the FSBS result was documented as 460.

Review of a physician's notification for Resident #1 dated 03/17/22 revealed a notification the resident's FSBS was 502 at 3:37pm.

Review of a physician's notification for Resident #1 revealed:
-On 03/22/22, a notification the resident's FSBS was 271 at 4:30pm and FSBS results from 02/28/22 at 8:49am through 03/03/22 at 9:35pm were attached.
-The attached page included 3 FSBS results greater than 401; on 02/28/22 FSBS 452, on 03/01/22 FSBS 425, and on 03/03/22 FSBS 412.

Review of Resident #1's March 2022 electronic progress notes revealed:
-On 03/07/22 at 12:11pm, 5 units of Humalog insulin was administered, and a physician was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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 273	Continued From page 5	D 273		

notified.
-On 03/13/22 at 11:51am, 5 units of Humalog insulin was administered, and a physician was notified.
-On 03/17/22 at 3:58pm, a physician was faxed FSBS results.
-On 03/22/22 at 11:56am, 5 units of Humalog insulin was given, and a physician was called.

Review of Resident #1's April 2022 eMAR revealed:
-An entry for Humalog sliding scale coverage SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-450 give 5 units and call endocrinology.
-On 04/03/22 at 4:00pm, the FSBS result was documented as 425.
-On 04/03/22 at 8:00pm, the FSBS result was documented as 540.
-On 04/04/22 at 7:00am, the FSBS result was documented as 467.
-On 04/06/22 at 4:00pm, the FSBS result was documented as 411.
-On 04/08/22 at 11:00am, the FSBS result was documented as 450.
-On 04/11/22 at 4:00pm, the FSBS result was documented as 415.

Review of Resident #1's April 2022 electronic progress notes revealed:
-On 04/03/22 at 10:19pm, the resident's FSBS was 425 before dinner, 540 after dinner and endocrinology was called and faxed.
-On 04/04/22 at 6:17am a physician was notified.

Review of a physician's notification for Resident #1 dated 04/03/22 revealed a notification the resident's FSBS was 540.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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 273	Continued From page 6 Review of physician notifications and electronic progress notes revealed there were no additional physician notifications documented for FSBS results greater than 401. Interview with a medication aide (MA) on 04/12/22 at 10:07am revealed: -She did not know she had to do anything for Resident #1's FSBS result of 436. -MAs contacted the physician by calling or faxing FSBS results over 500 and documented in the progress notes. Telephone interview with a second MA on 04/13/22 at 3:00pm revealed: -She was told to call the Health and Wellness Director (HWD) when Resident #1's FSBS was high. -The HWD would say she knew the resident had high FSBS. -The HWD told her not to call the physician and just give the insulin. -There was one occasion where the glucometer read "hi" where she had to notify the physician because the FSBS level was too high. Telephone interview with a medical office assistant at the Endocrinologist's office on 04/12/22 at 3:24pm revealed: -Every call from facility staff would come to the medical office assistants in the office. -The medical office assistant logged each call. -There were no calls on 04/12/22 regarding a FSBS of 436 for Resident #1. -She did not have information on the history of the resident's diabetes management; the physician or physician's assistant would have that information.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

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D 273	Continued From page 7 Interview with the Health and Wellness Director (HWD) on 04/13/22 at 4:36pm revealed: -She supervised MAs and the Resident Care Coordinator (RCC). -She had not done any trainings at the facility on contacting the physician. -She had spoken with staff on documentation in general; if something was not documented then it was not done. -Prior to 04/12/22, she did not know of the number of high FSBS levels that should have been reported to the Endocrinologist for Resident #1. -She was still learning the role of the HWD. -She had been able to audit some resident records, but Resident #1's was not one of those records. -She had not been contacted by any staff about high FSBS levels or delayed insulin administration for Resident #1. Interview with the Administrator on 04/13/22 at 5:20pm revealed: -All orders should include when to hold a medication and when to notify the physician. -MAs should be reporting FSBS results according to written parameters by calling and/or faxing if after hours. -Everything should be documented in the electronic progress notes including the FSBS result, what they did and any instructions the physician provided. -There was also an area named supplementary documentation on the electronic medication administration record (eMAR) where staff could enter a note. -Staff did not contact her regarding high FSBS results for Resident #1; the order clearly states to contact the physician.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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 273	Continued From page 8 Attempted telephone interviews with Resident #1's Endocrinologist on 04/12/22 at 4:05pm and on 04/13/22 at 2:42pm were unsuccessful. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/12/22 at 2:52pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. 2. Review of the Facility's Fall Policy on 04/13/22 revealed staff were to assist the resident and provide first aid or call 911 as indicated and follow the directions of the 911 operator when a fall occurred. Review of Resident #4's FL-2 dated 11/09/21 revealed: -Diagnoses included dementia, hypertension, anxiety, and chronic constipation. -The resident was intermittently disoriented. Review of the Facility's Incident Report dated 04/08/22 revealed: -Resident #4 had an unwitnessed fall and hit her head on the nightstand on 04/08/22 around 11:30pm. -The type of injury was a cut to the scalp. -The resident was provided first aid by staff. -The family member was notified of the fall and injury on 04/09/22 at 12:40am. -The Hospice Nurse was notified of the fall and head injury and would come to the facility in the morning to assess the resident. -The Hospice Nurse recommended to staff not to send the resident to the emergency room (ER) and to monitor her every 3 hours to ensure she	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

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D 273	Continued From page 9	D 273		

was stable.
-The family member came to the facility the next day (time not indicated) and insisted Resident #4 be sent to the ER.
-Resident #4 was transported to the ER by the emergency medical services (EMS) and received two staples to the scalp.

Review of Resident #4's hospital discharge summary dated 04/09/22 revealed:
-The reason for Resident #4's ER visit was a fall.
-Diagnosis included laceration of the scalp.
-The hospital provided laceration repair with staples.

Interview with Resident #4 on 04/12/22 at 9:30am revealed:
-She fell and hit her head.
-She could not recall the day.
-She was transported to the ER and received two staples to the scalp.

Interview with Resident #4's family member at 04/12/22 at 9:00am revealed:
-She was notified on 04/09/22 early in the morning (about an hour after midnight) that the resident fell out of bed and hit her head.
-She was told by staff the resident was fine.
-She came to the facility on 04/09/22 the next morning around 10:00am and observed the cut on Resident #4's scalp to be worse than she had thought.
-She insisted staff call the EMS to transport the resident to the ER for evaluation and treatment.
-The resident was transported to the ER and received two staples to the scalp.

Interview with the medication aide (MA) 04/13/22 at 5:37pm revealed:
-She discovered Resident #4 sitting upright on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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 273	Continued From page 10	D 273		

the floor beside her bed and nightstand on 04/08/22 around 11:30pm.
-There was a cut in the middle of her scalp less than a half an inch in size that was bleeding a small amount.
-She provided first aid and took vital signs.
-She did not think the injury was bad enough for the resident to be sent to the ER.
-She notified the Hospice nurse, the family member, the primary care provider (PCP), and the Health and Wellness Director (HWD) regarding the fall and injury and told them the resident was fine.
-The Hospice Nurse instructed her to not send the resident to the ER and she would come to the facility in the morning to assess the resident.
-The resident was not sent to the ER until the family member came to the facility (time not provided) the next day and insisted the resident be transported to the ER to evaluate the injury and treat the cut on the scalp.
-The resident was transported to the ER and received 2 staples to the scalp.

Interview with the Hospice Nurse on 04/13/22 at 3:21pm revealed:
-She was notified on 04/09/22, a little after midnight, that Resident #4 had fallen out of the bed and hit her head.
-The Hospice Nurse offered to come to the facility that night, but staff indicated the Resident #4 was fine.
-The Hospice Nurse instructed staff to monitor the resident for any changes and she would come to the facility the next day to assess.
-The Hospice Nurse instructed staff to send the resident to the ER if they felt it was indicated based on the injury.
-The facility was responsible for adhering to their policy and the wishes of the family regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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 273	Continued From page 11 residents on hospice care. Interview with the RCC on 04/13/22 at 3:00 pm revealed: -When a resident experienced a fall that resulted in a head injury, the resident should be sent to the ER for evaluation to ensure there was not a brain bleed or hemorrhage that could be life-threatening. -The Hospice Nurse was notified of the incident for their recommendation regarding how to proceed with the care of the resident. Interview with the HWD on 04/13/22 at 4:36pm revealed:4 -Resident #4 should have been sent to the ER for the fall that resulted in a head injury for evaluation for her safety. -If a resident is on hospice, the PCP and hospice were called first for recommendations on how to proceed regarding the management of the resident.. Interview with the Administrator on 04/13/22 at 5:28pm revealed: -She was aware of the fall that resulted in a cut to Resident #4's scalp on 04/08/22. -The facility notified hospice first for direction and guidance regarding Resident #4 fall and injury. -Her expectation was for the resident to be immediately sent to the ER for evaluation and management to ensure there were no internal injuries due to the fall that resulted in the resident hitting her head. _____ The facility failed to ensure referral and follow-up to meet the healthcare needs related to contacting the Endocrinologist for FSBS over 401 on multiple occasions and delayed insulin administration (#1) and seeking an emergency	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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 273	Continued From page 12 room evaluation and treatment after an unwitnessed fall with an open head wound delaying treatment for 12 hours that required wound closure with staples (#4). This failure created a substantial serious risk that harm will occur which constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/13/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 13, 2022.	D 273		
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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 3 of 5 residents (#1, #3 and #5) with errors of insulin administration (#1), narcotic pain relieving patches (#3) and a hypotensive medication (#5). The findings are:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

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D 358	Continued From page 13 Review of the facility's Medication and Treatment Administration policy dated 8/2010 with the latest revision on 03/31/22 revealed: -Medication assistance and administration should be in accordance with the prescriber's orders. -The individual assisting and/or administering the medication should check the label (3) times to verify the right medication, right dosage, right time and right method of administration before giving the medication. 1. Review of Resident #1's current FL-2 dated 11/09/21 revealed diagnoses included hyperlipidemia, dementia and type II diabetes mellitus. Review of Resident #1's signed physician's order summary report dated 02/22/22 revealed an order to check finger stick blood sugar (FSBS) four times daily before meals and at bedtime and notify the primary care provider (PCP) for results less than 50 or greater than 500. a. Review of an endocrinologist order for Resident #1 dated 04/08/22 revealed an order to increase Humalog to 7 units SQ four times daily before meals. (Humalog is a fast acting insulin used to treat hyperglycemia.) Review of an endocrinologist order for Resident #1 dated 04/08/22 revealed an order to increase Lantus to 12 units SQ every morning. (Lantus is a long acting insulin used to treat hyperglycemia.) Observations during the morning medication pass on 04/12/22 from 10:00am until 10:05am revealed: -At 10:00am Resident #1's FSBS was 436. -The MA administered Lantus 12 units at	D 358		

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D 358	Continued From page 14 10:04am. -The MA administered Humalog 7 units at 10:05am. Interview with the MA on 04/12/22 at 10:07am revealed: -She was not administering sliding scale insulin for the FSBS result of 436 at 10:00am. -The 3rd shift MA did FSBS checks for 1st shift (before 7:00am) and another check was being done at 10:00am because it was past due. -Resident #1 would have another FSBS check at 11:00am. -She did not have to administer insulin for the FSBS result of 436. -MAs contacted the physician by calling or faxing FSBS results over 500 and documented in the progress notes. Second interview with the MA on 04/12/22 at 1:00pm revealed: -She administered Resident #1's 7:30am dose of Humalog insulin at 10:05am today (04/12/22) during the morning medication pass. -She checked with the Health and Wellness Director (HWD) and was instructed to administer today's Humalog scheduled for 7:30am at 10:05am. -She let the PCP know what had happened when he was at the facility today (04/12/22). Interview with the HWD on 04/12/22 at 2:37pm revealed: -She was not aware the MA administered Resident #1's 7:30am dose of Humalog at 10:05am today (04/12/22). -She misunderstood what the MA was explaining related the resident's insulin administration times. -MAs were expected to give insulin at the scheduled times.	D 358		

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D 358	Continued From page 15 -The MA scheduled to work 1st shift today (04/12/22) was a no call no show so there was a delay in administering the resident's medications. -Resident #1's FSBS was checked by the 3rd shift MA today (04/12/22) and the result was 117 at 7:00am so the Humalog insulin scheduled for 7:30am should have been held. Third interview with the MA on 04/12/22 at 3:00pm revealed: -The 3rd shift MA checked Resident #1's FSBS at 6:00am. -At 7:30am the resident was due for scheduled Humalog and Lantus insulins. -She checked the resident's FSBS at 10:00am and covered the result of 436 with the 7:30am scheduled Humalog and administered the Lantus. -The eMAR system did not allow holding or not administering a dose of the scheduled Humalog without entering a FSBS result which was why she checked the FSBS at 10:00am. Second interview with the HWD on 04/12/22 at 3:00pm revealed: -The 04/12/22 7:30am dose of Humalog before meals should have been held and the physician should have been contacted for directions with on administering delayed doses. -The first shift MA was not present at shift change and did not know the FSBS result, so she rechecked the FSBS at 10:00am. -The 3rd shift MA should have entered the FSBS result on the electronic medication administration record (eMAR) and documented holding the 7:30am dose of Humalog due to the FSBS being less than 120. b. Review of subsequent orders for Resident #1 revealed: -A primary care provider (PCP) order dated	D 358		

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D 358	Continued From page 16	D 358		

02/01/22 for insulin Humalog 5 units subcutaneously (SQ) before meals; hold for FSBS less than 120.
-An Endocrinologist order dated 02/10/22 an order for insulin Humalog 3 units SQ four times daily before meals for poorly controlled diabetes mellitus.
-A signed physician's order summary report dated 02/22/22 order for insulin Humalog 3 units SQ before meals; hold for FSBS less than 120.
-An Endocrinologist order dated 03/23/22 revealed an order to increase insulin Humalog to 5 units SQ four times daily before meals.
-An Endocrinologist order dated 04/08/22 revealed an order to increase insulin Humalog to 7 units SQ four times daily before meals.

Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed:
-An entry starting 02/01/22 and ending 02/15/22 for Humalog insulin 5 units SQ before meals scheduled at 7:30am, 11:30am and 4:30pm, hold for FSBS less than 120.
-Documentation doses were administered from 4:30pm on 02/01/22 through 02/15/22 at 7:30am including 02/05/22 at 7:30am.
-A second entry beginning 02/15/22 and ending 02/28/22 for Humalog insulin 3 units SQ before meals scheduled at 7:30am, 11:30am and 4:30pm, hold for FSBS less than 120.
-Documentation doses were administered from 11:30am on 02/15/22 through 02/28/22.
-An entry for FSBS checks four times daily before meals and at bedtime with 13 of 112 FSBS results less than 120 at mealtimes including a FSBS of 101 on 02/05/22 at 6:30am where there was documentation a dose of Humalog insulin before meals was administered.

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D 358	Continued From page 17 Review of Resident #1's March 2022 eMAR revealed: -An entry beginning 03/01/22 and ending 03/30/22 for Humalog insulin 3 units SQ before meals scheduled at 7:30am, 11:30am and 4:30pm, hold for FSBS less than 120. -Documentation doses were administered from 7:30am on 03/01/22 through 11:30am on 03/30/22 except 5 doses which were held including 03/03/22 at 4:30pm and 03/21/22 at 11:30am. -A second entry starting 03/30/22 and ending 03/31/22 for Humalog insulin 5 units SQ before meals scheduled at 7:30am, 11:30am and 4:30pm, hold for FSBS less than 120. -Documentation of 4 doses administered from 4:30pm on 03/30/22 and 4:30pm on 03/31/22. -An entry for FSBS checks four times daily before meals and at bedtime with 3 of 112 FSBS results less than 120 at mealtimes. -On 03/03/22 at 4:30pm the FSBS result was 229 and on 03/21/22 at 11:30am the FSBS result was 577 where there was documentation doses of Humalog insulin before meals was held. Review of Resident #1's April 2022 eMAR revealed: -An entry beginning 04/01/22 and ending on 04/09/22 for Humalog insulin 5 units SQ before meals scheduled at 7:30am, 11:30am and 4:30pm, hold for FSBS less than 120. -Documentation doses were administered from 7:30am on 04/01/22 through 7:30am on 04/09/22 except 1 dose which was held on 04/01/22 at 7:30am. -A second entry starting 04/09/22 for Humalog insulin 7 units SQ before meals scheduled at 7:30am, 11:30am and 4:30pm, hold for FSBS less than 120. -Documentation doses were administered from	D 358		

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D 358	Continued From page 18 11:30am on 04/09/22 through 11:30am on 04/12/22 except 1 dose which was held on 04/09/22 at 11:30am. -An entry for FSBS checks four times daily before meals and at bedtime with 5 of 45 FSBS results less than 120 at mealtimes including FSBS of 113 at 4:30pm on 04/05/22, FSBS of 115 at 6:30am on 04/11/22 and FSBS of 117 on 04/12/22 where there was no documentation doses of Humalog insulin before meals was held. c. Review of an Endocrinologist order for Resident #1 dated 02/10/22 revealed an order for insulin Humalog sliding scale coverage SQ before meals and at bedtime, for FSBS less than 200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; and FSBS 351 plus give 4 units. Review of Resident #1's signed physician's order summary report dated 02/22/22 revealed an order for insulin Humalog sliding scale coverage SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-450 give 5 units and call endocrinology. Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed: -An entry beginning 01/30/22 and ending 02/01/22 for Humalog sliding scale insulin SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-500 give 5 units and call endocrinology; scheduled to be administered at 7:00am, 11:00am, 4:00pm and 8:00pm.	D 358		

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D 358	Continued From page 19 -A second entry starting 02/01/22 and ending 02/15/22 for Humalog sliding scale insulin SQ before meals and at bedtime, for FSBS 151-200 give 1 unit; FSBS 201-250 give 2 units; FSBS 251-300 give 5 units; FSBS 301-350 give 8 units; FSBS 351-400 give 11 units; FSBS 401-450 give 14; FSBS greater than 451 give 16 units and call the PCP; scheduled to be administered at 7:00am, 11:00am, 4:00pm and 8:00pm. -A third entry beginning 02/15/22 and ending 02/28/22 for Humalog insulin sliding scale coverage SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-450 give 5 units and call endocrinology; scheduled to be administered at 7:00am, 11:00am, 4:00pm and 8:00pm. -There were 4 results where the amount administered was not documented: FSBS = 517 on 02/17/22 at 11:00am; FSBS = 467 on 02/19/22 at 7:00am; FSBS = 467 on 02/19/22 at 11:00am; and FSBS = 600 on 02/24/22 at 11:00am. Review of Resident #1's March 2022 eMAR revealed: -An entry for Humalog insulin sliding scale coverage SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-450 give 5 units and call endocrinology; scheduled to be administered at 7:00am, 11:00am, 4:00pm and 8:00pm. -There were 12 results where the amount administered was not documented: FSBS = 475 on 03/04/22 at 7:00am; FSBS = 532 on 03/04/22 at 11:00am; FSBS = 586 on 03/06/22 at 11:00am; FSBS = 490 on 03/07/22 at 11:00am; FSBS = 458 on 03/13/22 at 11:00am; FSBS = 502 on	D 358		

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D 358	Continued From page 20 03/17/22 at 4:00pm; FSBS = 520 on 03/19/22 at 11:00am; FSBS = 529 on 03/19/22 at 8:00pm; FSBS = 468 on 03/20/22 at 11:00am; FSBS = 577 on 03/21/22 at 11:00am; FSBS = 458 on 03/22/22 at 11:00am; and FSBS = 460 on 03/25/22 at 11:00am. Review of an electronic progress note dated 03/04/22 for Resident #1 revealed a medication aide (MA) documented administering 8 units sliding scale insulin per the medication label and instructions from another MA. Review of Resident #1's April 2022 eMAR revealed: -An entry for Humalog insulin sliding scale coverage SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-450 give 5 units and call endocrinology; scheduled to be administered at 7:00am, 11:00am, 4:00pm and 8:00pm. -There were 3 results where the amount administered was not documented: FSBS = 540 on 04/03/22 at 8:00pm; FSBS = 467 on 04/04/22 at 7:00am; and FSBS = 415 on 04/11/22 at 4:00pm. Interview with the Health and Wellness Director (HWD) on 04/13/22 at 4:36pm revealed: -She supervised MAs and the Resident Care Coordinator (RCC). -She had not done any trainings at the facility on insulin administration. -She had spoken with staff on documentation in general; if it was not documented then it was not done. -She did not recall knowing anything about the progress note dated 03/04/22 documenting 8	D 358		

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D 358	Continued From page 21	D 358		

units of sliding scale insulin had been administered.
-Prior to 04/12/22, she did not know of the frequency of late insulin administrations for Resident #1.
-She was still learning the role of the HWD.
-She had been able to audit some resident records, but Resident #1's was not one of those records.
-She had not been contacted by any staff about insulin administration for Resident #1.

Interview with the Administrator on 04/13/22 at 12:25pm revealed:
-Insulin should be administered as ordered and held according to how the orders were written by the physician.
-The HWD had access to the eMAR system to monitor insulin administration and reporting of FSBS results to the physician.

Attempted telephone interview with a 1st shift medication aide on 04/13/22 at 2:38pm was unsuccessful.

Attempted telephone interview with a second 1st shift medication aide on 04/13/22 at 2:40pm was unsuccessful.

Attempted telephone interview with a 2nd shift medication aide on 04/13/22 at 3:38pm was unsuccessful.

Attempted telephone interview with Resident #1's Primary Care Provider on 04/12/22 at 2:52pm was unsuccessful.

Attempted telephone interviews with Resident #1's Endocrinologist on 04/12/22 at 4:05pm and on 04/13/22 at 2:42pm were unsuccessful.

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D 358	Continued From page 22 Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. 2. Review of Resident#3's current FL-2 dated 02/01/22 revealed: -Diagnoses included Parkinson's disease and history of cerebral vascular accident. -There was no documentation of cognitive impairment. Review of Resident #3's physician orders dated 03/01/22 revealed an order for hospice care. Review of Resident #3's progress notes dated 03/10/22 revealed: -He was found on the floor in his room. -Staff attempted to do range of motion (ROM) on his upper and lower extremities. -He screamed out in pain when staff did ROM on his upper extremities. -He was sent to the hospital with shoulder and hip pain. Review of Resident #3's hospital discharge instructions dated 03/10/22 revealed he had a fall with a closed head injury, injury to his cervical spinal ligament, and anterolisthesis (a slipped vertebrae) in his cervical spine. Review of Resident #3's physician orders dated 03/22/22 revealed an order for a Fentanyl 25mcg transdermal patch to be applied every 72 hours for pain. Observation of Resident #'s medications available for use on 04/13/22 at 8:57am revealed there were no Fentanyl patches available for use.	D 358		

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D 358	Continued From page 23 Interview with the Health and Wellness Director (HWD) on 04/13/22 at 9:02am revealed: -There were no patches available to give to Resident #3. -He would sometimes peel them off and she wanted to talk to hospice to see if he continued to need them. -He would let the staff know when he was in pain. Interview with Resident #3 on 04/13/22 at 9:47am revealed: -He was not currently in pain. -He had several falls recently. -He was not wearing a patch. Review of Resident #3's April 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Fentanyl 25mcg patch applied every 72 hours. -On 04/09/22, there was documentation the Fentanyl patch was not given due to waiting for a new prescription. -On 04/12/22, there was documentation the Fentanyl patch was not given due to needing pharmacy action. Telephone interview with the facility's contracted pharmacist on 04/13/22 at 2:20pm revealed: -The last time Fentanyl was dispensed was 03/22/22. -The pharmacy had not received a refill request from the facility. -The pharmacy faxed over a request to the hospice physician on 04/05/22 for a new prescription but had not received a response. Telephone interview with the Branch Director of Resident #3's hospice agency on 04/13/22 at 2:48pm revealed:	D 358		

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D 358	Continued From page 24	D 358		

-Hospice had not received a request from the facility for a medication refill for Resident #3's Fentanyl patches.
-Hospice will obtain prescriptions for the medications when requested by the facility.

Interview with a MA on 04/13/22 at 3:25pm revealed Resident #3's hospice wanted Resident #3's primary care physician to write the prescription for medication refills.

Second interview with the HWD on 04/13/22 at 4:28pm revealed:
-The Hospice Nurse for Resident #3 was in the facility every 1-2 weeks.
-The Hospice Nurse may have sent a medication request to the pharmacy but she was not sure.
-Staff should have called hospice when Resident #3 missed doses of his medication.

3. Review of Resident #5's current FL-2 dated 11/03/21 revealed:
-Diagnoses included hypotension and heart failure.
-There was no documentation that Resident #3 had cognitive impairment.

Review of Resident #5's physician orders dated 02/18/22 revealed an order for Midodrine 2.5mg (used for low blood pressure) if systolic blood pressure (SBP) was under 100 and diastolic blood pressure (DBP) was under 60.

Review of Resident #5's April 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for midodrine 2.5mg one tablet every day if her SBP was under 100 and DBP was under 60.
-Midodrine was documented as administered 6 of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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 25 12 days when her blood pressure was above the ordered parameters including: 04/02/22, her blood pressure was 120/60. 04/03/22, her blood pressure was 129/78. 04/05/22, her blood pressure was 170/146. 04/06/22, her blood pressure was 114/71. 04/09/22, her blood pressure was 133/88. 04/12/22, her blood pressure was 124/72. Interview with a medication aide (MA) on 04/13/22 at 3:20pm revealed: -The eMAR system will prompt the MA to take the blood pressure reading. -Once the blood pressure is entered into the system, the MA will document if the medication was administered. -If the medication was administered, a check mark would be documented in that date's entry. Interview with the Health and Wellness Director (HWD) on 04/13/22 at 4:28pm revealed: -Midodrine should not be given unless Resident #5's blood pressure was less than 100/60. -Midodrine was administered to Resident #5 when it was not needed according to the parameters. Interview with the Administrator on 04/13/22 at 5:31pm revealed staff are expected to follow the physician's orders when administering medications. _____ The facility failed to administer medications as ordered for 3 residents (#1, #3 and #5) including errors with insulin, narcotic pain-relieving patches and a hypotensive medication. The facility's failure resulted in poorly controlled type II diabetes mellitus (#1), unrelieved pain (#3) and the potential for elevated blood pressures (#5) which was detrimental to the health, safety and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 26 well-being of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/13/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 28, 2022.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour of the prescribed times for 1 of 5 residents (#1) resulting in the resident's insulin not being administered before meals. Review of Resident #1's current FL-2 dated 11/09/21 revealed diagnoses included hyperlipidemia, dementia and type II diabetes mellitus. a. Review of subsequent orders for Resident #1 revealed: -A primary care provider (PCP) order dated 02/01/22 for insulin Humalog 5 units subcutaneously (SQ) before meals; hold for FSBS less than 120. -An Endocrinologist order dated 02/10/22 an	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

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D 364	Continued From page 27	D 364		

order for insulin Humalog 3 units SQ four times daily before meals for poorly controlled diabetes mellitus.
-A signed physician's order summary report dated 02/22/22 order for insulin Humalog 3 units SQ before meals; hold for FSBS less than 120.
-An Endocrinologist order dated 03/23/22 revealed an order to increase insulin Humalog to 5 units SQ four times daily before meals.
-An Endocrinologist order dated 04/08/22 revealed an order to increase insulin Humalog to 7 units SQ four times daily before meals.

Observation outside the dining room on 04/13/22 at 1:49pm revealed there was a chalk board with mealtimes listed as 8:00am for breakfast, 12:00pm for lunch and 6:00pm for dinner.

Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed:
-An entry starting 02/01/22 and ending 02/15/22 for Humalog insulin 5 units SQ before meals scheduled at 7:30am, 11:30am and 4:30pm, hold for FSBS less than 120.
-A second entry beginning 02/15/22 and ending 02/28/22 for Humalog insulin 3 units SQ before meals scheduled at 7:30am, 11:30am and 4:30pm, hold for FSBS less than 120.

Review of Resident #1's February 2022 medication time variance report revealed:
-The 7:30am dose of Humalog insulin had been administered on 02/05/22 at 11:10am (with the scheduled 11:30am dose administered at 11:11am), on 02/06/22 at 11:36am (with the scheduled 11:30am dose administered at 11:38am), on 02/11/22 at 8:50am, on 02/13/22 at 9:47am, on 02/20/22 at 11:29am (with the scheduled 11:30am dose administered at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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 364	Continued From page 28	D 364		

11:28am), and on 02/28/22 at 8:49am.
-The 4:30pm dose of Humalog insulin had been administered on 02/09/22 at 5:52pm.
-The 11:30am dose of Humalog insulin had been administered on 02/10/22 at 1:57pm and on 02/16/22 at 4:40pm.
-The 4:30pm dose of Humalog insulin had been administered on 02/13/22 at 8:10pm, on 02/16/22 at 6:50pm, on 02/18/22 at 8:04pm, on 02/21/22 at 8:59pm, for 02/23/22 had been administered on 02/24/22 at 4:49am, on 02/24/22 at 8:49pm, on 02/25/22 at 9:43pm, and on 02/28/22 at 6:54pm.
-The Humalog insulin had been administered 17 out of 47 times greater than 90 minutes outside the scheduled administration times.

Review of Resident #1's March 2022 eMAR revealed:
-An entry beginning 03/01/22 and ending 03/30/22 for Humalog insulin 3 units SQ before meals scheduled at 7:30am, 11:30am and 4:30pm, hold for FSBS less than 120.
-A second entry starting 03/30/22 and ending 03/31/22 for Humalog insulin 5 units SQ before meals scheduled at 7:30am, 11:30am and 4:30pm, hold for FSBS less than 120.

Review of Resident #1's March 2022 medication time variance report revealed:
-The 7:30am dose of Humalog insulin had been administered on 03/06/22 at 10:52am (with the scheduled 11:30am dose administered at 10:39am), on 03/18/22 at 9:51am, on 03/19/22 at 11:25am (with the scheduled 11:30am dose administered at 11:25am), and on 03/20/22 at 11:02am (with the scheduled 11:30am dose administered at 11:03am).
-The 4:30pm dose of Humalog insulin had been administered on 03/02/22 at 6:25pm, 03/04/22 at 6:10pm, 03/08/22 at 7:12pm, and on 03/12/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

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D 364	Continued From page 29	D 364		

6:33pm.
-The Humalog insulin had been administered 8 out of 89 times greater than 90 minutes outside the scheduled times.

Review of Resident #1's April 2022 eMAR revealed:
-An entry beginning 04/01/22 and ending on 04/09/22 for Humalog insulin 5 units SQ before meals scheduled at 7:30am, 11:30am and 4:30pm, hold for FSBS less than 120.
-A second entry starting 04/09/22 for Humalog insulin 7 units SQ before meals scheduled at 7:30am, 11:30am and 4:30pm, hold for FSBS less than 120.

Review of Resident #1's April 2022 medication time variance report revealed:
-The 7:30am dose of Humalog insulin had been administered on 04/02/22 at 12:51pm (with the scheduled 11:30am dose administered at 12:50pm), on 04/03/22 at 11:40am (with the scheduled 11:30am dose administered at 11:39am), and on 04/12/22 at 9:59am.
-The Humalog insulin had been administered 3 out of 31 times greater than 90 minutes outside the scheduled times.

b. Review of a subsequent primary care provider (PCP) order for Resident #1 dated 02/01/22 revealed an order for insulin Humalog sliding scale coverage subcutaneous (SQ) before meals and at bedtime, for FSBS 151-200 give 1 unit; FSBS 201-250 give 2 units; FSBS 251-300 give 5 units; FSBS 301-350 give 8 units; FSBS 351-400 give 11 units; FSBS 401-450 give 14; FSBS greater than 451 give 16 units and call the PCP.

Review of an Endocrinologist order for Resident #1 dated 02/10/22 revealed an order for insulin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

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D 364	Continued From page 30	D 364		

Humalog sliding scale coverage SQ before meals and at bedtime, for FSBS less than 200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; and FSBS 351 plus give 4 units.

Review of Resident #1's signed physician's order summary report dated 02/22/22 revealed an order for insulin Humalog sliding scale coverage SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-450 give 5 units and call endocrinology.

Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed:
-An entry beginning 01/30/22 and ending 02/01/22 for Humalog sliding scale insulin SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-500 give 5 units and call endocrinology; scheduled to be administered at 7:00am, 11:00am, 4:00pm and 8:00pm.
-Documentation doses were administered on 02/01/22 at 7:00am and 11:30am.
-A second entry starting 02/01/22 and ending 02/15/22 for Humalog sliding scale insulin SQ before meals and at bedtime, for FSBS 151-200 give 1 unit; FSBS 201-250 give 2 units; FSBS 251-300 give 5 units; FSBS 301-350 give 8 units; FSBS 351-400 give 11 units; FSBS 401-450 give 14; FSBS greater than 451 give 16 units and call the PCP; scheduled to be administered at 7:00am, 11:00am, 4:00pm and 8:00pm.
-A third entry beginning 02/15/22 and ending 02/28/22 for Humalog insulin sliding scale

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 364	Continued From page 31	D 364		

coverage SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-450 give 5 units and call endocrinology; scheduled to be administered at 7:00am, 11:00am, 4:00pm and 8:00pm.

Review of Resident #1's February 2022 medication time variance report revealed:
-The 11:00am dose of Humalog sliding scale insulin had been administered on 02/10/22 at 1:56pm and on 02/16/22 at 4:39pm.
-The 4:00pm dose of Humalog sliding scale insulin had been administered on 02/08/22 at 8:41pm (with the scheduled 8:00pm dose administered at 8:40pm), on 02/13/22 at 8:09pm (with the scheduled 8:00pm dose administered at 8:10pm), on 02/16/22 at 6:49pm, on 02/21/22 at 8:58pm (with the scheduled 8:00pm dose administered at 8:59pm), on 02/24/22 at 8:48pm (with the scheduled 8:00pm dose administered at 8:50pm), on 02/25/22 at 9:42pm, and on 02/28/22 at 6:53pm (with the scheduled 8:00pm dose administered at 7:18pm).
-The 8:00pm dose of Humalog sliding scale insulin had been administered on 02/25/22 at 9:43pm.
-The Humalog sliding scale insulin had been administered 9 out of 77 times greater than 90 minutes outside the scheduled times.

Review of Resident #1's March 2022 eMAR revealed:
-An entry for Humalog insulin sliding scale coverage SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-450 give 5 units and call endocrinology;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 364	Continued From page 32	D 364		

scheduled to be administered at 7:00am, 11:00am, 4:00pm and 8:00pm.

Review of Resident #1's March 2022 medication time variance report revealed:
-The 4:00pm dose of Humalog sliding scale insulin had been administered on 03/02/22 at 6:24pm, on 03/04/22 at 6:08pm, on 03/08/22 at 7:11pm (with the scheduled 8:00pm dose administered at 7:13pm), on 03/12/22 at 6:32pm, and on 03/26/22 at 9:40pm.
-The 8:00pm dose of Humalog sliding scale insulin had been administered on 03/03/22 at 9:35pm, on 03/05/22 at 9:33pm, on 03/10/22 at 10:47pm, on 03/12/22 at 10:19pm, on 03/15/22 at 10:51pm, on 03/20/22 at 9:44pm, on 03/22/22 at 10:03pm, on 03/24/22 at 10:23pm, on 03/27/22 at 10:14pm, and on 03/28/22 at 9:47pm.
-The Humalog sliding scale insulin had been administered 15 out of 92 times greater than 90 minutes outside the scheduled times.

Review of Resident #1's April 2022 eMAR revealed an entry for Humalog insulin sliding scale coverage SQ before meals and at bedtime, for FSBS 151-200 give 0 units; FSBS 201-250 give 1 unit; FSBS 251-300 give 2 units; FSBS 301-350 give 3 units; FSBS 351-400 give 4 units; FSBS 401-450 give 5 units and call endocrinology; scheduled to be administered at 7:00am, 11:00am, 4:00pm and 8:00pm.

Review of Resident #1's April 2022 medication time variance report revealed there were no doses of Humalog sliding scale insulin documented as administered greater than 90 minutes outside the scheduled time.

Telephone interview with a medication aide on 04/13/22 at 3:00pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 364	Continued From page 33	D 364		

-She worked 2nd and 3rd shifts at the facility.
-When she arrived to work for 2nd shift, the 1st shift MA would tell her Resident #1 had just gotten her 11:30am insulin so she could not give the 4:30pm insulin.
-This was why the resident's FSBS levels were always high.
-This happened repeatedly.
-She was responsible for checking the morning FSBS before she left at the end of 3rd shift but was not able to administer the 7:30am Humalog.
-She had asked to be able to administer the 7:30am insulin before she left in the morning because the resident was consistently not getting the morning dose.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/13/22 at 2:21pm revealed:
-The onset for Humalog insulin was 45 minutes after administration and peaked 2.4 to 2.8 hours after administration.
-It was standard practice to administer Humalog before meals so the Humalog would peak as food was being digested.
-Food digesting caused the blood sugar level to rise.
-Delayed administration of Humalog would not offset the rising blood sugar level.

Interview with the Health and Wellness Director (HWD) on 04/13/22 at 4:36pm revealed:
-She supervised MAs and the Resident Care Coordinator (RCC).
-She had not done any trainings at the facility on insulin administration.
-Prior to 04/12/22, she did not know of the frequency of late insulin administrations for Resident #1.
-She knew of a few occasions where a MA was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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 364	Continued From page 34	D 364		

called in to cover a shift and there was a delay in medication administration.
-She was still learning the role of the HWD.
-She had been able to audit some resident records, but Resident #1's was not one of those records.
-She had not been contacted by any staff about delayed insulin administration for Resident #1.

Interview with the Administrator on 04/13/22 at 12:25pm revealed:
-MAs were expected to administer medications one hour before to one hour after the scheduled time.
-Insulin should be administered as ordered and held according to how the orders were written by the physician.
-The HWD had access to the eMAR system to monitor insulin administration and reporting of FSBS results to the physician.

Attempted telephone interview with a 1st shift medication aide on 04/13/22 at 2:38pm was unsuccessful.

Attempted telephone interview with a second 1st shift medication aide on 04/13/22 at 2:40pm was unsuccessful.

Attempted telephone interview with a 2nd shift medication aide on 04/13/22 at 3:38pm was unsuccessful.

Attempted telephone interview with Resident #1's Primary Care Provider on 04/12/22 at 2:52pm was unsuccessful.

Attempted telephone interviews with Resident #1's Endocrinologist on 04/12/22 at 4:05pm and on 04/13/22 at 2:42pm were unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

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D 364	Continued From page 35 Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	D 364		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and medication administration. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up to meet the healthcare needs for 2 of 5 sampled residents (#1 and #4) after an unwitnessed fall with a head injury (#4) and for elevated blood sugar levels and delayed insulin administration (#1). [Refer to Tag D 273, 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
D912	Continued From page 36 observed during the morning medication pass with errors of insulin administration (#1) and for 3 of 5 residents (#1, #3 and #5) sampled for record review including errors with insulin (#1), narcotic pain relieving patches (#3) and a hypotensive medication (#5). [Refer to Tag D 358 10A NCAC 13F .1004 (a) Medication Administration (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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
D935	Continued From page 37 developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain documentation of 15 hour medication administration training for 1 of 5 medication aides (Staff E) sampled for medication aide training. The findings are: Review of Staff E's personnel record revealed: -Staff E was hired 09/21/21 as a medication aide (MA). -She passed her medication aide examinatione 05/21/09 and her medication skills checkoff on 10/05/21. -There was no documentation of the required 15 hours of medication aide training or a medication verification form. Review of Resident #5's electronic Medication Administration Record dated February 2022 revealed: -Staff E documented the administration of medications to Resident #5. -Staff E documented administering medications	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	04/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(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
D935	Continued From page 38 including blood thinners, controlled medications, and eye drops. Interview with the Resident Care Coordinator (RCC) on 04/13/22 at 5:25pm revealed: -Staff E had worked in another facility in the same company previously. -The other facility had the documentation of Staff E's medication training. -The RCC was waiting for the documentation to be sent over from the other facility.	D935		