STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

(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 November 14-15, 2023.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 2 sampled residents (#2) with a texture modified diet order. The findings are: Review of Resident #2's current FL-2 dated 02/06/23 revealed: -Diagnoses included dementia, dehydration, hypoxia, psychotic disturbance, mood disturbance, anxiety, and chronic obstructive pulmonary disease. -There was a order for a "texture modified" diet and a nutritional supplement two times daily with meals. Review of Resident #2's diet order sheet dated 02/03/20 revealed: -The texture modified diet offered food that was moist and soft-solid. -All meats and poultry were ground with the exception being small, tender pieces of meat allowed in soups. -It was expected that mixed textures were	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

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D 310	Continued From page 1 tolerated on this diet. Observations during the initial kitchen tour on 11/14/23 at 10:30am revealed: -There was a resident nutrition tracker report posted on the wall. -Resident #2 was listed on the nutrition tracker report as requiring a texture modified diet. Observation of breakfast service for Resident #2 on 11/15/23 at 7:30am revealed: -Eggs, bacon/sausage, oatmeal, and fruit were on the menu. -A personal care aide (PCA) began to serve Resident #2 her meal, writer intervened before the resident began to eat. -The plate consisted of oatmeal, toast, sausage, and scrambled eggs. -The PCA informed the kitchen staff and Resident #2 received a texture modified plate. Interview with the PCA who served Resident #2 her plate during breakfast service on 11/15/23 at 7:45am revealed: -She mistakenly gave Resident #2 the wrong plate. -The food cart from the kitchen did not have Resident #2's therapeutic diet plate on it. -There were cards with each resident's name on the food cart to indicate which plate they were to be served. -She gave Resident #2 another resident's plate. Interview with the Dining Services Manager on 11/15/23 at 8:15am revealed: -He thought Resident #2 was in the hospital because she had been sent out the afternoon before. -He did not put Resident #2's therapeutic diet plate on the food cart.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

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BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

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D 310	Continued From page 2 -The PCA informed the kitchen staff Resident #2 needed her therapeutic diet plate, which staff then prepared. -Resident #2's therapeutic diet plate consisted of ground sausage patty, scrambled eggs, soft bread, and oatmeal. -It was the kitchen staff's responsibility to prepare all therapeutic diets. Telephone interview with Resident #5's primary care provider (PCP) on 11/15/23 at 3:30pm revealed: -He was concerned that Resident #2 could choke on her food or not eat her food completely due to not being served her proper diet. -He expected the facility to follow the diet order for Resident #2. Interview with the Executive Director on 11/15/23 at 2:40pm revealed: -The kitchen staff had a modified diet list. -Kitchen staff plated the residents' food and placed a name card on the cart to indicate which plate belongs to which resident. -PCA's were expected to read the card and give each resident the correct plate.	D 310		
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.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

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BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

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D 358	Continued From page 3	D 358		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 4 residents observed during the medication pass including errors with a pain medication (#6) and an iron supplement (#7); and for 2 of 5 sampled residents (#2, #5) for record review including errors with medications for heart and blood pressure (#2, #5).

The findings are:

1. The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 8:00am/9:00am medication pass on 11/14/23 and the 8:00am medication pass on 11/15/23.

a. Review of the facility's policy and procedure for medication administration of a new order dated August 2022 revealed:
-All currently ordered medications would be available to the resident.
-The facility was responsible for obtaining newly ordered medications or refills for medications, and treatment orders.

Review of Resident #6's current FL-2 dated 06/23/23 revealed diagnoses included bursitis of left knee, Parkinson's disease, and lumbar fusion/back pain.

Review of Resident #6's new prescription summary dated 11/13/23 revealed an order for Tramadol 50mg, take ½ tablet by mouth once a day in the morning. (Tramadol is an opioid medication used to treat moderate to severe pain.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

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D 358	Continued From page 4 Observation of the 8:00am medication pass on 11/14/23 revealed: -The medication aide (MA) prepared and administered Resident #6's 8:00am and 9:00am medications at 10:35am. -Resident #6 was not administered Tramadol 50mg, ½ tablet, that was scheduled at 9:00am. Review of Resident #6's November 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Tramadol 50mg administer ½ tablet in the morning for pain scheduled at 9:00am. -The medication was documented as administered at 9:00am on the eMAR from 11/09/23-11/13/23. Observation of Resident #6's medications on hand on 11/14/23 at 1:38pm revealed: -There was a supply of 3 ½ Tramadol 50mg tablets dispensed on 11/13/23 with instructions to give ½ tablet every morning. There were 2 ½ tablets remaining. Interview with Resident #6 on 11/14/23 at 4:05pm revealed: -Her medications were normally administered late after 9:00am. -Her pain had been worse since her last fall several months ago. Interview with the MA on 11/14/23 at 1:33pm revealed: -Resident #6's Tramadol was not in the facility and available for administration during the morning medication pass on 11/14/23. -The medication arrived around 11:30am and was administered to Resident #6 at that time.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

(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 5	D 358		

-Resident #6's Tramadol should have been sent with the medications that were delivered to the facility on 11/13/23.
-Resident #6's Tramadol was documented as administered at 9:00am because that was when it was scheduled to be administered.

Interview with the Resident Care Coordinator (RCC) on 11/14/23 at 3:10pm revealed:
-Resident #6's Tramadol was requested on 11/13/23 and the pharmacy did not send the medication.
-The pharmacy sent the Tramadol on 11/14/23 through backup.
-The pharmacy usually sent a few tablets to get the resident through until the next delivery, which was tonight, 11/14/23.

Interview with the Health and Wellness Director (HWD) on 11/15/23 at 10:20am revealed:
-The pharmacy did not have the hard prescription for Resident #6's Tramadol on 11/13/23.
-She was not sure why the Tramadol was not in the facility on time to be administered on 11/14/23.
-The MAs should have documented the Tramadol on the controlled substance sheet at the time the medication was administered not when it was ordered.
-The MAs should have documented a late entry on the eMAR when the medication was administered late on 11/14/23.
-The MAs had been trained on how to document on the controlled substance sheet and how to document when a medication was administered late on the eMAR.

Interview with the Administrator on 11/15/23 at 10:33am revealed Resident #6's Tramadol should have been documented on the controlled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

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D 358	Continued From page 6	D 358		

substance sheet and eMAR when they were administered.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/15/23 at 2:00pm revealed the Tramadol was dispensed on 11/14/23, a 3-day supply, after receiving the prescription from the provider.

Telephone interview with the facility's contracted primary care provider (PCP) at 3:30pm on 11/15/23 revealed:
-A new prescription was sent to the wrong pharmacy on 11/13/23 and he corrected it on 11/13/23.
-He had no concerns about Resident #6 receiving the Tramadol late on 11/14/23 since it was a new medication.
-He was trying the Tramadol to help relieve some of the resident's pain.

b. Review of Resident #7's current FL-2 dated 05/15/23 revealed:
-Diagnoses including spinal stenosis, hip pain, muscle weakness, and unspecified anemia.
-There was an order for Ferrous Sulfate 325mg one tablet daily every other day. (Ferrous Sulfate is used to treat iron deficiency anemia. Ferrous Sulfate is enteric coated and should not be crushed or chewed.)

Review of Resident #7's physician's orders dated 09/25/23 revealed an order for Ferrous Sulfate 325mg one tablet one time a day.

Observation of the morning medication pass on 11/15/23 at 7:57am revealed:
-The medication aide (MA) crushed all of Resident #7's oral pills including Ferrous Sulfate and administered them in applesauce.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

(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		

-Ferrous Sulfate was enteric coated and should not be crushed.
-The MA did not use a Do Not Crush list to determine which medications could be crushed.

Review of Resident #7's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Ferrous Sulfate 325mg every day scheduled at 8:00am.
-Ferrous Sulfate was documented as administered daily from 11/01/23 - 11/15/23.
-There was no documentation on the eMAR related to crushing Resident #6's Ferrous Sulfate.

Observation of Resident #7's medications on hand on 11/15/23 at 9:58am revealed:
-There was a supply of Ferrous Sulfate dispensed on 10/25/23.
-The instructions on the medication label were to take one tablet by mouth every day "DO NOT CRUSH".

Interview with the MA on 11/15/23 at 10:00am revealed:
-The MA had not seen "DO NOT CRUSH" on the medication label.
-The MA normally crushed Resident # 7's medication when she administered medications to the resident.
-There was not a Do Not Crush list on the medication cart.

Interview with the Resident Care Coordinator (RCC) on 11/15/23 at 10:08am revealed:
-The MAs should not crush medications when the label stated, do not crush.
-The MAs had been taught not to crush medications with instructions, "do not crush".
-The MA should have notified the pharmacy and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

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D 358	Continued From page 8	D 358		

provider to let them know the resident's medications were being crushed.

Interview with the Health and Wellness Director (HWD) on 11/15/23 at 10:20am revealed:
-The MAs had been taught not to crush medications when the label stated, do not crush.
-There was a Do Not Crush list in the medication room.
-The MAs had been trained to compare the medication label with the eMAR before administering the medications.
-The MAs were responsible for entering medications and instructions in the eMAR system.
-A second MA checked behind the MA who entered the medication and instructions.
-The RCC checked all medication orders to ensure they were entered correctly.

Interview with the Administrator on 11/15/23 at 10:33am revealed:
-The MAs had been taught to not crush medications if the instructions stated, do not crush.
-She was not sure if there was a Do Not Crush list on the medication cart.

Interview with Resident #7 on 11/15/23 at 10:42am revealed her stomach was fine and not hurting.

Telephone interview with facility's contracted primary care provider (PCP) on 11/15/23 at 3:30pm revealed:
-It was concerning the Ferrous Sulfate was crushed because it could have interfered with the absorption of the medication and could have caused stomach irritation.
-It was concerning that the instructions are not

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	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

(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	D 358		

followed on the medication label.

2. Review of Resident #5's current FL-2 dated 07/31/23 revealed diagnoses included urinary tract infection, spinal stenosis, essential primary hypertension, apraxia following cerebral infraction, and aphasia following cerebral infraction.

Review of Resident #5's physician's orders dated 10/25/23 revealed an order for Losartan 25mg tablet, take one tablet daily by mouth. (Losartan is used to treat high blood pressure.)

Review of Resident #5's October and November 2023 electronic medication administration records (eMARs) revealed:
-There were no entries for Losartan 25mg on either eMAR.
-There were no documented high blood pressure results for weekly vitals.

Observations of Resident #5's medications on hand on 11/15/23 at 2:00pm revealed Losartan 25mg tablets were not available on the medication cart.

Interview with a medication aide (MA) on 11/15/23 at 10:45am revealed:
-The MA or the Health and Wellness Director (HWD) were responsible for faxing new medication orders to the pharmacy to be filled.
-The pharmacy would be contacted for verification that new medication orders were received.
-Once the new medication was verified by the pharmacy, the MA would put the new medication into the system.

Interview with the HWD on 03/22/23 at 11:45am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

(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	D 358		

revealed:
-It was the responsibility of the MA and HWD to order new medications and make sure they were available for the resident.
-The MA placed the new medication order in the resident's record and failed to order the medication.
-Resident #5 should have been receiving Losartan 25mg.

Interview with the Administrator on 03/22/23 at 11:45am revealed:
-A new medication was faxed to the facility from the primary care provider (PCP).
-MAs were responsible for getting the medication ordered from the pharmacy and putting it into the eMAR system.
-The MA who received the fax for the new prescription order did not put the new order in the system or did it incorrectly.

Telephone interview with Resident #5's PCP 11/15/23 at 3:30pm revealed:
-He was not concerned about Resident #5 missing the Losartan 25mg tablet.
-He preferred Resident #5 to take the Losartan 25mg daily as it was prescribed.

3. Review of Resident #2's current FL-2 dated 02/06/23 revealed:
-Diagnoses included dementia, dehydration, hypoxia, psychotic disturbance, mood disturbance, anxiety, and chronic obstructive pulmonary disease.
-There was an order for Irbesartan 300mg 1 tablet daily, check blood pressure (BP) and hold Irbesartan for systolic blood pressure (SBP) less than (<) 100 or diastolic blood pressure (DBP) < 50. (Irbesartan is used to treat high blood pressure.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

(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	D 358		

-There was an order for Metoprolol Succinate ER 50mg take 1 tablet once daily, check BP and hold Metoprolol Succinate ER if SBP <100 or DBP <50. (Metoprolol Succinate ER is used to lower BP and heart rate.)

Review of Resident #2' September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Irbesartan 300mg 1 tablet one time a day for hypertension (high blood pressure) scheduled at 8:00am.
-There was an entry for Metoprolol Succinate ER 50mg 1 tablet one time a day for blood pressure scheduled at 8:00am.
-There was an entry to check BP daily, hold Irbesartan and Metoprolol Succinate ER for SBP <100 or DBP <50 scheduled at 8:00am.
-The resident's BP was documented as 98/53 on 09/04/23 at 8:00am.
-Irbesartan and Metoprolol Succinate ER were both documented as administered on 09/04/23 at 8:00am instead of being held as ordered.
-The resident's BP on the next day, 09/05/23 at 8:00am, was documented as 112/67.
-The resident's BP ranged from 98/53 - 181/95 from 09/01/23 - 09/30/23.

Interview with a medication aide (MA) on 11/15/23 at 2:31pm revealed:
-She was unsure why Resident #2's BP medications were not held on 09/04/23 when the resident's BP was below the parameters.
-She did not recall and could not explain why she documented that she administered the BP medications when they should have been held.

Interview with the Health and Wellness Director (HWD) on 11/15/23 at 4:06pm revealed:
-The MAs were responsible for reading the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092027	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MACARTHUR PARK	111 MACARTHUR DRIVE CARY, NC 27513

(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 instructions on the eMAR and administering medications as ordered. -Resident #2's BP medications should have been held on 09/04/23 when the resident's BP was below the ordered parameters. Telephone interview with Resident #2's primary care provider (PCP) on 11/15/23 at 3:34pm revealed: -Resident #2's Irbesartan and Metoprolol Succinate ER should be held based on the ordered parameters. -He was not too concerned about Resident #2's Irbesartan and Metoprolol Succinate ER not being held on 09/04/23 since the resident's BP had a tendency to run low and he was not aware of the resident having any symptoms of low BP that day.	D 358		