STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G305	A. BUILDING _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKWOOD	313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298

(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) COMPLETION DATE
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure all drugs were administered to 1 of 3 sample clients (client #3) without error. The finding is: Observation in the group home on 03/29/23 at 7:39 AM revealed client #3 to enter the mediation room for medication administration and retrieve her medication box. Continued observation revealed client #3 to receive Benztropine 0.5 mg from staff A. Further observation revealed staff A omitted administering client #3's prescribed Gavilax Power. Review of records on 3/29/23 revealed a current habilitation support plan (HSP) dated 11/28/22. Review of the HSP revealed client #3 has a goal to assist with medication administration skills, and needs to increase independence in medication administration - identify medication. Further review of records revealed a Physicians order dated 2/27/23 for 8:00 Am medications consisting of Benztropine 0.5 mg and Gavilax powder. Interview with the homes registered nurse (RN) on 3/29/23 revealed staff are trained in medication administration. Continued interview with the RN revealed, the physicians order contains a detailed summary of the prescribed medications each client is to receive at each designated medication pass. Further interview with the RN revealed they will retrain the med tech staff again regarding the procedural	W 369		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 369	Continued From page 1 guidelines and expectations of the medication administration.	W 369		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, record review, and interview the system for drug administration failed to assure 1 of 3 sample clients (#3) and 1 non-sampled client (#4) observed during medication administration were provided the opportunity to participated in medication self-administration or provided teaching relative to the purpose and side effects of medication administered. The findings are: A. The system for drug administration failed to assure client #3 was provided the opportunity to participate in self-administration. For example: Observation in the group home on 03/29/23 at 7:39 AM revealed client #3 to enter the mediation room for medication administration and retrieve her medication box. Continued observation revealed client #3 to receive Benztropine 0.5 mg from staff A in a bubble pack and consumed with water. Interview with the homes registered nurse (RN) on 3/29/23 revealed staff are trained in medication administration. Continued interview with the RN revealed, the physicians order	W 371		

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W 371	Continued From page 2	W 371		

contains a detailed summary of the prescribed medications each client is to receive at each designated medication pass. Further interview with the RN revealed they will retrain the med tech staff again regarding the procedural guidelines and expectations of the medication administration.

B. The system for drug administration failed to assure client #4 was provided the opportunity to participate in medication self-administration. For example:

Observation in the home on 3/29/23 at 7:30 AM revealed client to enter the medication room and retrieve her medication box. Further observations revealed staff A retrieve client #4's medications: levothyroxine 0.15 mg, gabapentin 400 mg, olanzapine 5 mg, vitamin B-6 50 Mg, Escitalopram 5 mg, levetiracetam 750 mg, naltrexone 50 mg, acetaminophen 650 mg, lithium 300 mg, and daily vitamin prepackaged in one bubble pack. Continued observation revealed staff A to administer the medications to client #4 with water. Client #4 was not observed to receive any training during medication pass or to participate beyond taking the medications and staff A gave no explanation to her regarding the purpose for the medications.

Interview with the homes registered nurse (RN) on 3/29/23 revealed staff are trained in medication administration. Continued interview with the RN revealed, the physicians order contains a detailed summary of the prescribed medications each client is to receive at each designated medication pass. Further interview with the RN revealed they will retrain the med tech staff again regarding the procedural

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W 371	Continued From page 3 guidelines and expectations of the medication administration.	W 371		
W 463	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(4) The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets. This STANDARD is not met as evidenced by: Based on observation, record review and interview the agency failed to ensure 1 of 3 sample clients (#1) received the IDT prescribed diet at the breakfast meal. The finding is: Observation in the group home on 3/29/23 revealed client #1 to eat a breakfast meal consisting of the following: two pancakes with syrup, scrambled eggs, water and orange juice. Continued observation of the breakfast meal revealed client #1 to be assisted with her meal by staff E. Further observation of the breakfast meal revealed client #1 to be offered orange juice and not her prescribed fresh fruit. Review of records on 3/29/23 revealed a current habilitation support plan (HSP) dated 11/30/23 listing the current diet as: regular 1500 -1800 calories per day healthy weight loss, blood sugar control diet, and, fruit should be given in place of juice at breakfast. Continue review of records revealed a medical evaluation dated 11/2/22 that indicates client #1 should be given a fruit at breakfast in place of a juice. Further review of records revealed nutritional evaluation dated 01/24/23 that states client #1 should be given a fruit at breakfast in place of a juice. Interview with the homes registered nurse (RN)	W 463		

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W 463	Continued From page 4 on 3/29/23 revealed that the fresh fruit is given to client #1 at breakfast to help increase her A1C levels. Continued interview with the RN revealed that staff have been trained on the clients diet. Further interview with the RN revealed the diet cards are in the homes' kitchen.	W 463		