Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032019	A. BUILDING: _____ B. WING _____	R 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHAPEL HILL	2230 FARMINGTON DRIVE CHAPEL HILL, NC 27514

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D 000	Initial Comments The Adult Care Licensure Section completed a follow up survey from 08/26/25 to 08/27/25.	D 000	The following is the Plan of Correction for Brookdale Cary regarding the Statement of Deficiencies dated 08/27/25 This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective	
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#1) for record review including an inhaler and a medication for constipation. The findings are: Review of Resident #1's current FL-2 dated 09/17/25 revealed diagnoses included amnesia, chronic obstructive pulmonary disease (COPD), and failure to thrive. a. Review of Resident #1's signed physician's order dated 04/01/25 revealed there was an order for Symbicort inhaler 160-4.5 mcg/act (used to treat COPD) two puffs twice daily. Review of Resident #1's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Symbicort inhaler 160-4.5	D 358	Executive Director or designee will verify residents' records for treatments and/or orders from the physician and their implementation. Health and Wellness Coordinator or designee will audit resident records for order implementation. To assist with ongoing compliance, the Executive Director or designee will audit resident records once a month for six (6) months and quarterly for two (2) quarters.	9/30/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Iwona Hughes | TITLE: ED | (X6) DATE: 9/4/25

Reviewed and acknowledged 09.19.25

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mcg/act two puffs twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Symbicort inhaler was administered 61 of 62 opportunities from 07/01/25 to 07/31/25.
-There was one exception documented; the exception was the resident refused.

Review of Resident #1's August 2025 eMAR from 08/01/25 to 08/25/25 revealed:
-There was an entry for Symbicort inhaler 160-4.5 mcg/act two puffs twice daily.
-There was documentation Symbicort inhaler was administered 50 of 50 opportunities from 08/01/25 to 08/26/25.

Observation of medications on hand for Resident #1 revealed there was a Symbicort inhaler with 50 of 120 inhalations available for administration dispensed on 05/22/25.

Telephone interview with a representative from the facility's contracted pharmacy on 08/26/25 at 3:34pm revealed:
-Resident #1 had an order for Symbicort inhaler 160-4.5 mcg/act two puffs twice daily dated 04/01/25.
-The pharmacy dispensed a Symbicort inhaler on 04/01/25 and 05/22/25.
-Each Symbicort inhaler contained 120 inhalations and would last 30 days based on the order as written.
-The Symbicort inhaler was not on cycle fill; the facility had to re-order the medication when it was needed.
-The facility had not requested a refill for Symbicort inhaler since 05/22/25.

Telephone interview with a medication aide (MA) on 08/27/25 at 8:34am revealed:

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-She administered Resident #1's Symbicort inhaler as ordered.
-Resident #1 did not have shortness of breath.
-She did not know why the Symbicort inhaler had not been re-ordered since 05/22/25.
-Resident #1 had panic attacks and would start breathing fast.
-She would check Resident #1's oxygen saturation and it would be in the 90s.
-She would administer medication for anxiety and placed Resident #1's oxygen on at 2L/M.
-Resident #1 would calm down and breath easier after the oxygen was started and medication for anxiety was administered.

Telephone interview with another MA on 08/27/25 at 10:10am revealed:
-She administered Symbicort inhaler to Resident #1 every morning as ordered.
-She did not know why the Symbicort inhaler still had medication in the inhaler since she had administered the medication as ordered.

Telephone interview with a nurse at the Hospice Home Health Agency on 08/25/27 at 11:03am revealed:
-She assessed Resident #1 weekly.
-Resident #1's oxygen saturation was in the 90's most of the time.
-When Resident #1's oxygen saturation was less than 90, she would place the oxygen on Resident #1 at 2L/M and Resident #1's oxygen saturation would return to the 90's.
-Resident #1 became anxious at times that would cause her to breathe rapidly, but the MAs had orders to administer anxiety medications as needed.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 08/27/25 at 9:37am

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revealed:
-Resident #1 was ordered the Symbicort inhaler for COPD.
-She had not been notified that Resident #1 was having any problems with shortness of breath.
-She was aware that Resident #1 one received Hospice services who was also treating Resident #1 for anxiety.
-She expected the facility to administer medications as ordered.

Interview with the Health and Wellness Coordinator (HWC) on 08/27/25 at 11:20am revealed:
-Resident #1 did not complain of shortness of breath.
-She had an order for Symbicort inhaler two puffs twice daily.
-The Symbicort inhaler had 120 inhalations and would last 30 days.
-It appeared the medication was not being administered as ordered since it had not been dispensed since 05/22/25.
-The MA would administered medication for Resident #1's anxiety and the oxygen when Resident #1 became anxious.
-She expected the MAs to administer medications as ordered.

Interview with the Administrator on 08/27/25 at 11:58am revealed:
-Inhalers were not cycle filled; they had to be re-ordered when needed.
-The MAs were responsible for re-ordering medications by notifying the pharmacy.
-Resident #1 could have difficulty breathing if she was not administered her inhaler as ordered.
-She expected the MAs to administer medications as ordered.

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Refer to the interview with the HWC on 08/27/25 at 11:20am.

Refer to the interview with the Administrator on 08/27/25 at 11:58am.

b. Review of Resident #1's signed physician's order dated 05/29/25 revealed there was an order for polyethylene glycol 17gms (used for constipation) one packet every 3 days.

Review of Resident #1's July 2025 eMAR revealed:
-There was an entry for polyethylene glycol 17gms one packet every 3 days with a scheduled administration time of 8:00am.
-There was documentation polyethylene glycol was administered 9 of 10 opportunities from 07/01/25 to 07/31/25.
-There was one exception documented; the exception was the resident refused.

Review of Resident #1's August 2025 eMAR from 08/01/25 to 08/26/25 revealed:
-There was an entry for polyethylene glycol 17gms one packet every 3 days with a scheduled administration time of 8:00am.
-There was documentation polyethylene glycol was administered 9 of 9 opportunities from 08/01/25 to 08/25/25.

Observation of medications on hand for Resident #1 revealed there were 23 of 30 polyethylene glycol packets available for administration dispensed on 05/05/25.

Telephone interview with a representative from the facility's contracted pharmacy on 08/26/25 at 3:34pm revealed:
-Resident #1 had an order for polyethylene glycol

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17gms one packet every three days dated 05/05/25.
-The pharmacy dispensed 30 packets of polyethylene glycol 17gms on 05/06/25.
-Polyethylene glycol was not on cycle fill; the facility had to re-order the medication when it was needed.
-Polyethylene glycol had not been requested to be refilled since the original order was filled on 05/06/25.

Interview with a personal care aide (PCA) on 08/27/25 at 8:33am revealed:
-Resident #1 had regular bowel movements.
-Resident #1 did not have any problems with constipation.

Telephone interview with a MA on 08/27/25 at 8:34am revealed:
-She administered polyethylene glycol to Resident #1 as ordered.
-Resident #1 did not have any problems with constipation.
-Resident #1 had regular bowel movements
-She did not know why the polyethylene had not been re-ordered since 05/22/25 and why there were so many packets of medication remaining.

Telephone interview with Resident #1's PCP on 08/27/25 at 9:37am revealed:
-The facility had not reported any recent complications with constipation with Resident #1.
-She discontinued the ferrous sulfate (a supplement) a few months ago due to Resident #1 being constipated.
-She expected the facility to administer medications as ordered.

Interview with the HWC on 08/27/25 at 11:20am revealed:

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D 358	Continued From page 6 -Resident #1 did not have a problem with constipation. -Resident #1 did have a problem with constipation when Resident #1 was taking ferrous sulfate (a supplement) but the PCP discontinued the medication. -It appeared the medication was not being administered as ordered since it had not been dispensed since 05/22/25. -She expected the MAs to administer medications as ordered. Interview with the Administrator on 08/27/25 at 11:58am revealed: -Resident #1 could have a problem with constipation if she did not receive the medication as ordered. -She expected the MAs to administer medications as ordered. Refer to the interview with the HWC on 08/27/25 at 11:20am. Refer to the interview with the Administrator on 08/27/25 at 11:58am. _____ Interview with the HWC on 08/27/25 at 11:20am revealed: -The RCC was responsible for auditing the medication cart with a MA, however the facility did not have a RCC since Friday, 08/22/25. -She did not know who would be responsible for the medication cart audits since the facility did not have a RCC. -She thought the medication cart audits were done weekly, but she was not sure. -Medications in the medication cart should be compared to the medications listed on the eMAR. -She did not know if the RCC and MA looked at the dispensed date of the medication when doing	D 358		

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D 358	Continued From page 7 a medication audit. -She had done one medication cart audit when she was trained by someone in management. Interview with the Administrator on 08/27/25 at 11:58am revealed: -Medication carts were audited by the HWD, the HWC, and the RCC. -She thought there was a rotating schedule for medication carts to be completed quarterly. -The medication cart auditors made sure the medication on the medication cart matched the medication listed on the eMAR and removed expired and discontinued medications.	D 358		