

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/27/2025
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NAME OF PROVIDER OR SUPPLIER BROOKDALE CHAPEL HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 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		
D 358	<p>10A NCAC 13F .1004 (a) Medication Administration</p> <p>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:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>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.</p> <p>The findings are:</p> <p>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.</p> <p>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.</p> <p>Review of Resident #1's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Symbicort inhaler 160-4.5</p>	D 358		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 358	<p>Continued From page 1</p> <p>mcg/act two puffs twice daily with a scheduled administration time of 8:00am and 8:00pm.</p> <p>-There was documentation Symbicort inhaler was administered 61 of 62 opportunities from 07/01/25 to 07/31/25.</p> <p>-There was one exception documented; the exception was the resident refused.</p> <p>Review of Resident #1's August 2025 eMAR from 08/01/25 to 08/25/25 revealed:</p> <p>-There was an entry for Symbicort inhaler 160-4.5 mcg/act two puffs twice daily.</p> <p>-There was documentation Symbicort inhaler was administered 50 of 50 opportunities from 08/01/25 to 08/26/25.</p> <p>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.</p> <p>Telephone interview with a representative from the facility's contracted pharmacy on 08/26/25 at 3:34pm revealed:</p> <p>-Resident #1 had an order for Symbicort inhaler 160-4.5 mcg/act two puffs twice daily dated 04/01/25.</p> <p>-The pharmacy dispensed a Symbicort inhaler on 04/01/25 and 05/22/25.</p> <p>-Each Symbicort inhaler contained 120 inhalations and would last 30 days based on the order as written.</p> <p>-The Symbicort inhaler was not on cycle fill; the facility had to re-order the medication when it was needed.</p> <p>-The facility had not requested a refill for Symbicort inhaler since 05/22/25.</p> <p>Telephone interview with a medication aide (MA) on 08/27/25 at 8:34am revealed:</p>	D 358		

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D 358	<p>Continued From page 2</p> <ul style="list-style-type: none"> -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. <p>Telephone interview with another MA on 08/27/25 at 10:10am revealed:</p> <ul style="list-style-type: none"> -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. <p>Telephone interview with a nurse at the Hospice Home Health Agency on 08/25/27 at 11:03am revealed:</p> <ul style="list-style-type: none"> -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. <p>Telephone interview with Resident #1's Primary Care Provider (PCP) on 08/27/25 at 9:37am</p>	D 358		

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D 358	<p>Continued From page 3</p> <p>revealed:</p> <ul style="list-style-type: none"> -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. <p>Interview with the Health and Wellness Coordinator (HWC) on 08/27/25 at 11:20am revealed:</p> <ul style="list-style-type: none"> -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. <p>Interview with the Administrator on 08/27/25 at 11:58am revealed:</p> <ul style="list-style-type: none"> -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. 	D 358		

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D 358	<p>Continued From page 4</p> <p>Refer to the interview with the HWC on 08/27/25 at 11:20am.</p> <p>Refer to the interview with the Administrator on 08/27/25 at 11:58am.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	D 358		

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D 358	<p>Continued From page 5</p> <p>17gms one packet every three days dated 05/05/25.</p> <p>-The pharmacy dispensed 30 packets of polyethylene glycol 17gms on 05/06/25.</p> <p>-Polyethylene glycol was not on cycle fill; the facility had to re-order the medication when it was needed.</p> <p>-Polyethylene glycol had not been requested to be refilled since the original order was filled on 05/06/25.</p> <p>Interview with a personal care aide (PCA) on 08/27/25 at 8:33am revealed:</p> <p>-Resident #1 had regular bowel movements.</p> <p>-Resident #1 did not have any problems with constipation.</p> <p>Telephone interview with a MA on 08/27/25 at 8:34am revealed:</p> <p>-She administered polyethylene glycol to Resident #1 as ordered.</p> <p>-Resident #1 did not have any problems with constipation.</p> <p>-Resident #1 had regular bowel movements</p> <p>-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.</p> <p>Telephone interview with Resident #1's PCP on 08/27/25 at 9:37am revealed:</p> <p>-The facility had not reported any recent complications with constipation with Resident #1.</p> <p>-She discontinued the ferrous sulfate (a supplement) a few months ago due to Resident #1 being constipated.</p> <p>-She expected the facility to administer medications as ordered.</p> <p>Interview with the HWC on 08/27/25 at 11:20am revealed:</p>	D 358		

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D 358	<p>Continued From page 6</p> <ul style="list-style-type: none"> -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. <p>Interview with the Administrator on 08/27/25 at 11:58am revealed:</p> <ul style="list-style-type: none"> -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. <p>Refer to the interview with the HWC on 08/27/25 at 11:20am.</p> <p>Refer to the interview with the Administrator on 08/27/25 at 11:58am.</p> <hr/> <p>Interview with the HWC on 08/27/25 at 11:20am revealed:</p> <ul style="list-style-type: none"> -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	<p>Continued From page 7</p> <p>a medication audit.</p> <p>-She had done one medication cart audit when she was trained by someone in management.</p> <p>Interview with the Administrator on 08/27/25 at 11:58am revealed:</p> <p>-Medication carts were audited by the HWD, the HWC, and the RCC.</p> <p>-She thought there was a rotating schedule for medication carts to be completed quarterly.</p> <p>-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.</p>	D 358		