STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(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 09/08/21 to 09/10/21.	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: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 3 sampled residents (#2) related to scheduling a dental appointment for the resident's tooth pain and failure to schedule a follow up appointment in two days with the residents' primary care physician after being discharged from the emergency department for a wound. The findings are: Review of Resident #2's current FL-2 dated 02/22/21 revealed diagnoses included Alzheimer's, transient ischemic attacks (mini strokes), atrial fibrillation (an irregular heart rate), hypothyroidism (underactive thyroid), and aphasia (partial or total loss of the ability to communicate verbally or using written words). 1. Interview with the medication aide (MA) on 09/09/21 at 8:36am revealed: -Resident #2 received pain medication this morning (09/09/21) for a tooth ache and the medication made her sleepy. -Resident #2 was scheduled for a dental procedure on 09/21/21.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

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BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

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D 273	Continued From page 1	D 273		

Interview with the Health and Wellness Director on 09/09/02 at 3:17pm revealed:
-Resident #2 had a tooth extraction on 06/22/21 and was scheduled to return to the dentist approximately 6 weeks later but the dental office had to cancel the appointment.
-Resident #2's follow up dental appointment had been rescheduled for 09/21/21.

Telephone interview with the receptionist at Resident #2's dental office on 09/10/21 at 10:41am revealed if Resident #2 was in pain and needed to be seen, the dentist could see her next week to reassess her sooner than 09/21/21.

Interview with the Health and Wellness Director on 09/10/21 at 11:00am revealed:
-She should have contacted Resident #2's dentist to schedule an appointment due to her toothache.
-She had not contacted Resident #2's PCP to report the tooth ache.

Interview with the Executive Director on 09/10/21 at 11:05am revealed:
-She expected the Health and Wellness Director to notify Resident #2's primary care physician (PCP) and dentist of her tooth ache.
-The Health and Wellness Director should have made a follow up appointment as soon as possible since Resident #2 had tooth ache pain.

Attempted telephone interview with Resident #6's PCP on 09/10/21 at 9:09am was unsuccessful.

Based on observations and interviews, it was determined Resident #2 was uninterviewable.

2. Review of Resident #2's electronic progress note dated 08/21/21 revealed:
-There was an electronic entry on 08/21/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(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 2	D 273		

9:24pm written by a Medication Aide (MA) that the resident was discovered on the floor.
-The resident was bleeding on her left hand by her thumb and there appeared to be a hole on the wound.
-Emergency medical services (EMS) were contacted for transport the resident to a local emergency department in case she required stitches.

Review of an Incident and Accident Report for Resident #2 dated 08/21/21 at 9:00pm revealed:
-The resident had an unwitnessed fall in her room and had a skin tear on her left hand.
-The injury needed emergency room treatment and an assessment.
-There were no follow up entries on the Incident and Accident Report.

Review of Resident #2's discharge summary dated 08/21/21 revealed the resident was stable for discharge and needed to follow up with her primary care physician (PCP) in 2 days to assess her wound.

Interview with the Health and Wellness Director on 09/09/02 at 3:17pm revealed:
-She requested a copy of the discharge summary for Resident #3 on 08/23/21.
-She never received a fax from the local emergency department.
-She was not aware that the discharge summary had instructions for the resident to follow up with her PCP in 2 days for the wound.

Interview with the Administrator on 09/10/21 at 4:02pm revealed:
-She expected the Health and Wellness Director to obtain a copy of the discharge summary from the local emergency department for Resident #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(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 -She expected the Health and Wellness Director to follow up on any emergency room visits or hospitalizations. -She expected the Health and Wellness Director to coordinate follow up appointments for residents to ensure they received the proper care. Attempted telephone interview with Resident #2's PCP on 09/10/21 at 9:09am was unsuccessful.	D 273		
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 before or after the prescribed or scheduled times for 5 of 5 residents observed (#1, #6, #7, #8, and #10) on the assisted living (AL) side of the facility resulting in medications ordered multiple times a day being administered too close to the next scheduled administration time. The findings are: Review of the facility's General Guidelines for Medication Administration dated 06/20 revealed medications and treatments should be	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

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D 364	Continued From page 4	D 364		

administered within 1 hour before or one hour after the prescribed frequency and time unless ordered by the healthcare provider or according to state regulation.

Review of the facility's census on 09/08/21 revealed there were 14 residents in the assisted living (AL) side and 8 residents in the special care unit (SCU).

Interview with a medication aide (MA) on 09/09/21 at 8:03am revealed:
-She worked the previous night shift.
-She was waiting for the day shift MA to arrive on the AL side.
-She completed the 7:00am medication pass for the facility.

Observation of the SCU on 09/09/21 from 8:05am to 8:57am revealed there was one MA on the medication cart passing medications.

Observation of the AL on 09/09/21 from 9:40am to 11:15am revealed there was one MA on the medication cart passing medications.

Interview with the MA on the AL side on 09/09/21 at 9:40am revealed she still had 2 residents to administer morning medication to on the 200 hallway and 5 residents to administer morning medications to on the 100 hallway.

1. Review of Resident #6's current FL-2 dated 10/12/20 revealed diagnoses included hypertension and coronary artery heart disease.

Review of Resident #6's September 2021 electronic medication administration record (eMAR) revealed:
-There were 9 medications scheduled to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

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D 364	Continued From page 5	D 364		

administered at 8:00am.
-There were 2 medications scheduled to be administered at 8:00am and 8:00pm.

Observation of the medication aide (MA) administering morning medications on 09/09/21 revealed she entered Resident #6's room with his medications scheduled for 8:00am at 10:07am and exited at 10:09am.

Refer to the interview with the medication aide (MA) administering medications on the assisted living (AL) side on 09/09/21 at 2:02pm.

Refer to the interview with the medication aide (MA) administering medications on the special care unit (SCU) side on 09/09/21 at 2:34pm.

Refer to the interview with the Health and Wellness Director on 09/09/21 at 3:25pm.

Refer to the interview with the Administrator on 09/09/21 at 4:02pm.

Attempted telephone interview with Resident #6's primary care physician on 09/10/21 at 9:09am was unsuccessful.

2. Review of Resident #1's current FL-2 dated 02/05/21 revealed diagnoses included rheumatoid arthritis, hypertension, cerebral infarct, major depressive disorder and bipolar disease.

Review of Resident #1's September 2021 electronic medication administration record (eMAR) revealed:
-There were 10 medications scheduled to be administered at 8:00am.
-There were 2 medications scheduled to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(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 6	D 364		

administered at 8:00am and 8:00pm.
-There was 1 medication scheduled to be administered at 8:00am and 1:00pm.
-There was an entry for Tylenol 325mg, give three tablets three times a day scheduled to be administered at 8:00am, 2:00pm, and 8:00pm (Tylenol is used to treat mild pain).
-There was an entry for Lorazepam 1mg, give one tablet three times a day scheduled to be administered at 8:00am, 2:00pm, and 8:00pm (Lorazepam is used to treat anxiety).

Observation of the medication aide (MA) administering morning medications on 09/09/21 revealed she administered Resident #1's medications scheduled for 8:00am at 10:22am.

Refer to the interview with the medication aide (MA) administering medications on the assisted living (AL) side on 09/09/21 at 2:02pm.

Refer to the interview with the medication aide (MA) administering medications on the special care unit (SCU) side on 09/09/21 at 2:34pm.

Refer to the interview with the Health and Wellness Director on 09/09/21 at 3:25pm.

Refer to the interview with the Administrator on 09/09/21 at 4:02pm.

Attempted telephone interview with Resident #6's primary care physician on 09/10/21 at 9:09am was unsuccessful.

3. Review of Resident #7's current FL-2 dated 09/08/20 revealed diagnoses included Parkinson's disease, hypertension, atrial fibrillation (abnormal heart rhythm), dementia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(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 7	D 364		

Review of Resident #7's September 2021 electronic medication administration record (eMAR) revealed:
-There were 4 medications scheduled to be administered at 9:00am.
-There was an entry for Norco 5-325mg three times a day, scheduled for administration at 9:00am, 2:00pm, and 8:00pm (Norco is used to treat pain).
-There was an entry for Sinement 25-250mg four time a day, scheduled for administration at 9:00am, 12:00pm, 4:00pm, 8:00pm.

Observation of the medication aide (MA) administering morning medications on 09/09/21 revealed she entered Resident #7's room with his medications scheduled for 9:00am at 10:35am and exited at 10:40am.

Refer to the interview with the medication aide (MA) administering medications on the assisted living (AL) side on 09/09/21 at 2:02pm.

Refer to the interview with the medication aide (MA) administering medications on the special care unit (SCU) side on 09/09/21 at 2:34pm.

Refer to the interview with the Health and Wellness Director on 09/09/21 at 3:25pm.

Refer to the interview with the Administrator on 09/09/21 at 4:02pm.

Attempted telephone interview with Resident #7's primary care physician on 09/10/21 at 9:09am was unsuccessful.

4. Review of Resident #8's current FL-2 dated 09/08/20 revealed diagnoses included hypertension, atrial fibrillation (abnormal heart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(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 8	D 364		

rhythm), cardiomyopathy, and congestive heart failure.

Review of Resident #8's September 2021 electronic medication administration record (eMAR) revealed:
-There were 2 medications scheduled to be administered at 8:00am.
-There were 5 medications scheduled to be administered at 9:00am and 8:00pm.
-There was an entry for Tylenol 500mg three times a day, scheduled for administration at 9:00am, 2:00pm, and 8:00pm (Tylenol is used to treat mild pain).

Observation of the medication aide (MA) administering morning medications on 09/09/21 revealed she entered Resident #8's room with her medications scheduled for 8:00am and 9:00am at 10:42am and exited at 10:40am.

Refer to the interview with the medication aide (MA) administering medications on the assisted living (AL) side on 09/09/21 at 2:02pm.

Refer to the interview with the medication aide (MA) administering medications on the special care unit (SCU) side on 09/09/21 at 2:34pm.

Refer to the interview with the Health and Wellness Director on 09/09/21 at 3:25pm.

Refer to the interview with the Administrator on 09/09/21 at 4:02pm.

Attempted telephone interview with Resident #8's primary care physician on 09/10/21 at 9:09am was unsuccessful.

5. Review of Resident #10's current FL-2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(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 9 09/08/20 revealed diagnoses included gastroesophageal reflux disease, constipation, anemia, Alzheimer's disease, hypertension, anxiety disorder, and osteoarthritis. Review of Resident #10's September 2021 electronic medication administration record (eMAR) revealed: -There were 3 medications scheduled to be administered at 8:00am. -There were 3 medications scheduled to be administered at 9:00am. Observation of the medication aide (MA) administering morning medications on 09/09/21 revealed she entered Resident #10's room with her medications scheduled for 8:00am and 9:00am at 10:59am and exited at 11:10am. Refer to the interview with the medication aide (MA) administering medications on the assisted living (AL) side on 09/09/21 at 2:02pm. Refer to the interview with the medication aide (MA) administering medications on the special care unit (SCU) side on 09/09/21 at 2:34pm. Refer to the interview with the Health and Wellness Director on 09/09/21 at 3:25pm. Refer to the interview with the Administrator on 09/09/21 at 4:02pm. Attempted telephone interview with Resident #10's primary care physician on 09/10/21 at 9:09am was unsuccessful. _____ Interview with the medication aide (MA) administering medications on the assisted living (AL) side on 09/09/21 at 2:02pm revealed:	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(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 10 -She was running behind with the morning medication pass because she was covering a shift. -When she arrived for her shift around 8:45am the night shift MA had not started the morning medication pass. -If she was covering until another MA arrived she would have started passing the scheduled medications so the MA would not be behind and the residents would receive their medication on time. -She was usually finished with the morning medication pass on the AL side by 9:30am. -The Health and Wellness Director helped if staff asked but she did not ask her today. -She was concerned about the timing of the three times a day and four times a day medication being administered too close together when the morning medications were delayed. Interview with the MA administering medications on the special care unit (SCU) side on 09/09/21 at 2:34pm revealed: -She was not aware the night shift MA had not started passing medications on the AL side. -She was not aware the AL MA was behind on her medication pass because she would have assisted her to pass medications. Interview with the Health and Wellness Director on 09/09/21 at 3:25pm revealed: -She was not aware that the night shift MA that stayed over to cover until the day shift MA arrived had not started the morning medication pass on the AL side. -The night shift MA that stayed over to cover was expected to start passing medications until the day shift MA arrived so the medications would be on time.	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(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 11 Interview with the Administrator on 09/09/21 at 4:02pm revealed she expected medications to be administered following the facility's policy of one hour before and one hour after the scheduled administration time.	D 364		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure the medication administration record was accurate for 2 of 3 residents sampled (#2 and #1) related to a pain medication (#2) and a medication for anxiety (#1).	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

(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 367	Continued From page 12	D 367		

The findings are:

1. Review of Resident #2's current FL-2 dated 02/22/21 revealed diagnoses of Alzheimer's, malignant neoplasm of the colon (colon cancer), anxiety, insomnia, and other arthritis.

Review of a Resident #2's physician's orders dated 02/22/21 revealed an order for Tramadol 50mg one tablet every 6 hours as needed for pain (Tramadol is used to treat pain).

Review of Resident #2's July 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Tramadol 50mg one tablet every 6 hours as needed for pain.
-There was documentation 2 doses of Tramadol 50mg were administered on 07/05/21 and 07/07/21.

Review of a controlled substance count sheet (CSCS) dated 07/05/21 through 07/21/21 revealed:
-There was documentation of 8 tablets of Tramadol 50mg signed out for Resident #2.
-There were 8 tablets of Tramadol 50mg not documented as administered on Resident #2's July 2021 eMAR; 07/06/21, 07/08/21, 07/15/21, 07/18/21, 07/20/21 and 07/21/21.

Review of Resident #2's August 2021 eMAR revealed:
-There was an entry for Tramadol 50mg one tablet every 6 hours as needed for pain.
-There was documentation 7 doses of Tramadol 50mg were administered on 08/14/21, 08/16/21, 08/22/21 at 9:30am and 08/22/21 at 9:00pm, 08/23/21, 08/27/21 and 08/31/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 13 Review of a CSCS dated 08/14/21 through 08/31/21 revealed: -There was documentation of 9 tablets of Tramadol 50mg signed out for Resident #2. -There were 2 tablets of Tramadol 50mg not documented as administered on Resident #2's August 2021 eMAR; 08/26/21 and 08/28/21. Review of Resident #2's September 2021 eMAR revealed: -There was an entry for Tramadol 50mg one tablet every 6 hours as needed for pain. -There was documentation 4 doses of Tramadol 50mg were administered on 09/01/21, 09/02/21, 09/05/21 and 09/06/21. Review of a CSCS dated 09/01/21 through 09/06/21 revealed: -There was documentation of 2 tablets of Tramadol 50mg signed out for Resident #2. -There were 2 tablets of Tramadol 50mg not documented as administered on Resident #2's September 2021 eMAR; 09/03/21 and 09/04/21. Refer to the interview with the Health and Wellness Director on 09/09/21 at 3:25pm. Refer to the interview with the Administrator on 09/09/21 at 4:02pm. Attempted telephone interview with Resident #2's primary care provider (PCP) on 09/10/21 at 9:09am was unsuccessful. 2. Review of Resident #1's current FL-2 dated 02/05/21 revealed diagnoses included major depressive disorder and bipolar disease. Review of Resident #1's physician's orders dated	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ELIZABETH CITY	401 HASTINGS LANE ELIZABETH CITY, NC 27909

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D 367	Continued From page 14 04/21/21 revealed an order for Lorazepam 1mg to be given three times a day (Lorazepam is used to treat anxiety). Observation of Resident #1's morning medication pass on 09/09/21 at 10:22am revealed she received her morning medication including Lorazepam 1mg. Review of Resident #1's controlled substance count sheet for Lorazepam 1mg revealed 1 pill was administered on 09/09/21 at 10:15am. Review of Resident #1's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 1mg, scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Lorazepam 1mg was documented as administered on 09/09/21 at 8:00am. Refer to the interview with the Health and Wellness Director on 09/09/21 at 3:25pm. Refer to the interview with the Administrator on 09/09/21 at 4:02pm. Attempted telephone interview with Resident #1's primary care provider (PCP) on 09/10/21 at 9:09am was unsuccessful. _____ Interview with the Health and Wellness Director on 09/09/21 at 3:25pm revealed: -She expected the electronic medication administration record (eMAR) to be accurate and complete. -When medication aides (MA) administered a medication they should document on the controlled substance count sheet (CSCS) and the	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070005	A. BUILDING: _____ B. WING _____	C 09/10/2021

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D 367	Continued From page 15 eMAR. -The documentation on the eMAR should match the CSCS. Interview with the Administrator on 09/09/21 at 4:02pm revealed she expected the electronic medication administration record to be accurate and complete.	D 367		