STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065002	A. BUILDING: _____ B. WING _____	04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COMMONS AT BRIGHTMORE	2320 FORTY-FIRST STREET WILMINGTON, NC 28403

(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 04/26/22 to 04/28/22.	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 to meet the health care needs for 1 of 7 sampled residents (#3) who refused medications to treat cognitive disorders and hypertension. The findings are: Review of Resident #3's current FL-2 dated 12/02/21 revealed: -Diagnoses included Parkinson's disease, dementia, and hypertension (HTN) -He was constantly disoriented and semi-ambulatory. Review of Resident #3's current care plan dated 03/16/22 revealed he wandered, was always disoriented, and had significant memory loss requiring direction. Review of Resident #3's current FL-2 dated 12/02/21 revealed: -There were orders for Lamotrigine 25mg once daily (used to treat seizures and bipolar disorder), Metoprolol Tartrate 12.5mg twice daily (used to treat high blood pressure), Seroquel 50mg in the	D 273		

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morning and 25mg twice daily to be administered at 3:00pm and bedtime (used to treat schizophrenia, bipolar, and depression), Rivastigmine 4.6mg/24hr administer one patch daily (used to treat dementia), and Sinemet 25-100mg take 1.5 tablets three times daily (used to treat Parkinson's disease).

a. Review of Resident #3's physician's order summary report dated 03/16/22 revealed there was an order for Lamotrigine 25mg once daily to treat dementia.

Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Lamotrigine 25mg daily to be administered at 9:00am.
-There was documentation Lamotrigine was not administered to the resident on 04/09/22, 04/16/22, and 04/26/22 because the resident refused the medication.
-There was no documentation Resident #3's Primary Care Provider was notified the resident refused Lamotrigine.

Review of Resident #3's March 2022 eMAR revealed:
-There was an entry for Lamotrigine 25mg once daily to be administered at 9:00am.
-There was documentation Lamotrigine was not administered to the resident on 03/02/22, 03/05/22, 03/12/22, and 03/29/22 because the resident refused the medication.
-There was no documentation Resident #3's PCP was notified the resident refused Lamotrigine.

Review of Resident #4's February 2022 eMAR revealed:
-There was an entry for Lamotrigine 25mg once

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daily to be administered at 9:00am.
-There was documentation Lamotrigine was not administered to the resident 03/03/22, 03/06/22, 03/11/22, 03/16/22, 03/21/22 to 03/23/22, and 03/25/22 because the resident refused the medication.
-There was no documentation Resident #3's PCP was notified the resident refused Lamotrigine.

Review of the facility's progress notes from 02/01/22 to 04/26/22 for Resident #3 revealed there was no documentation the resident's PCP was notified Lamotrigine was refused.

Refer to interview with the Administrator on 04/28/22 at 9:07am.

Refer to interview with the Area Director (AD) for 200 Hall on 04/28/22 at 9:50am.

Refer to interview with a medication aide (MA) on 04/28/22 at 10:45am

Refer to telephone interview with Resident #3's Primary Care Provider (PCP) on 04/28/22 at 11:52am.

Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.

b. Review of Resident #3's physician's order summary report dated 03/16/22 revealed there was an order for Metoprolol Tartrate 12.5mg twice daily.

Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Metoprolol 12.5mg twice

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daily to be administered at 9:00am and 5:00pm.
-There was documentation Metoprolol was not administered to the resident on 04/09/22, 04/16/22, and 04/26/22 at 9:00am and on 04/08/22 at 5:00pm because the resident refused the medication.
-The resident's blood pressure was documented as refused on 04/14/22.
-There was no documentation Resident #3's Primary Care Provider (PCP) was notified the resident refused the medication.

Review of Resident #3's March 2022 eMAR revealed:
-There was an entry for Metoprolol 12.5mg twice daily to be administered at 9:00am and 5:00pm.
-There was documentation Metoprolol was not administered to the resident on 03/02/22, 03/05/22, and 03/29/22 at 9:00am; 03/04/22 5:00pm; and 03/12/22 at 9:00am and 5:00pm because the resident refused.
-The resident's blood pressure was documented as 116/68 on 03/14/22.
-There was no documentation Resident #3's PCP was notified the resident refused the medications.

Review of Resident #3's February 2022 eMAR revealed:
-There was an entry for Metoprolol 12.5mg twice daily to be administered at 9:00am and 5:00pm.
-There was documentation Metoprolol was not administered to the resident on 02/03/22, 02/06/22, 02/11/22, 02/16/22, 02/21/22 to 02/23/22 and 02/25/22 at 9:00am and on 02/12/22 to 02/13/22 and 02/26/22 to 02/27/22 at 5:00pm because the resident refused the medication.
-The residents blood pressure was documented as 90/51 on 02/07/22.

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D 273	Continued From page 4 -There was no documentation Resident #3's PCP was notified the resident refused the medications. Review of the facility's progress notes from 02/01/22 to 04/26/22 for Resident #3 revealed there was no documentation the resident's PCP was notified Metoprolol was refused. Refer to interview with the Administrator on 04/28/22 at 9:07am. Refer to interview with the Area Director (AD) for 200 Hall on 04/28/22 at 9:50am. Refer to interview with a medication aide (MA) on 04/28/22 at 10:45am Refer to telephone interview with Resident #3's Primary Care Provider (PCP) on 04/28/22 at 11:52am. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. c. Review of Resident #3's physician's order summary report dated 03/16/22 revealed there was an order for Seroquel 25mg twice daily to be administered at 3:00pm and bedtime to treat dementia with behavioral disturbances. Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Seroquel 25mg to be administered at 3:00pm and 9:00pm. -There was documentation Seroquel was not administered to the resident on 04/06/22, 04/10/22 and 04/24/22 at 9:00pm because the resident refused the medication.	D 273		

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D 273	Continued From page 5 -There was no documentation Resident #3's Primary Care Provider was notified the resident refused the medication. Review of Resident #3's March 2022 eMAR revealed: -There was an entry for Seroquel 25mg to be administered at 3:00pm and 9:00pm. -There was documentation Seroquel was not administered to the resident on 03/02/22 to 03/03/22, 03/06/22, 03/14/22, 03/24/22 and 03/29/22 at 3:00pm and on 03/04/22, 03/13/22, 03/22/22, and 03/30/22 at 9:00pm because the resident refused the medication. -There was no documentation Resident #3's PCP was notified the resident refused the medication. Review of Resident #3's February 2022 eMAR revealed: -There was an entry for Seroquel 25mg to be administered at 3:00pm and 9:00pm. -There was documentation Seroquel was not administered on 02/04/22, 02/11/22, 02/13/22, 02/16/22, 02/19/22, 02/22/22 to 02/23/22, 02/25/22, and 02/27/22 at 3:00pm; 02/02/22, and 02/26/22 to 02/27/22 at 9:00pm; and 02/12/22, 02/21/22. -There was no documentation Resident #3's PCP was notified the resident refused the medication. Review of the facility's progress notes from 02/01/22 to 04/26/22 for Resident #3 revealed there was no documentation the resident's PCP was notified Seroquel 25mg was refused. Refer to interview with the Administrator on 04/28/22 at 9:07am. Refer to interview with the Area Director (AD) for 200 Hall on 04/28/22 at 9:50am.	D 273		

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D 273	Continued From page 6 Refer to interview with a medication aide (MA) on 04/28/22 at 10:45am Refer to telephone interview with Resident #3's Primary Care Provider (PCP) on 04/28/22 at 11:52am. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. d. Review of Resident #3's physician's order summary report dated 03/16/22 revealed there was an order for Seroquel 50mg once daily to treat dementia with behavioral disturbances. Review of Resident #3's April electronic medication administration record (eMAR) revealed: -There was an entry for Seroquel 50mg once daily to be administered at 9:00am. -There was documentation Seroquel was not administered on 04/09/22 04/16/22, and 04/26/22 because the resident refused the medication. -There was no documentation Resident #3's Primary Care Provider (PCP) was notified the resident refused the medication. Review of Resident #3's March 2022 eMAR revealed: -There was an entry for Seroquel 50mg once daily to be administered at 9:00am. -There was documentation Seroquel was not administered to the resident on 03/02/22, 03/05/22, 03/12/22, and 03/29/22 because the resident refused the medication. -There was no documentation Resident #3's PCP was notified the resident refused the medication.	D 273		

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Review of Resident #3's February 2022 eMAR revealed:
-There was an entry for Seroquel 50mg once daily to be administered at 9:00am.
-There was documentation Seroquel was not administered on 02/03/22, 02/06/22, 02/11/22, 02/16/22, 02/21/22 to 02/23/22, and 02/25/22 because the resident refused the medication.
-There was no documentation Resident #3's PCP was notified the resident refused the medication.

Review of the facility's progress notes from 02/01/22 to 04/26/22 for Resident #3 revealed there was no documentation the resident's PCP was notified Seroquel 50mg was refused.

Refer to interview with the Administrator on 04/28/22 at 9:07am.

Refer to interview with the Area Director (AD) for 200 Hall on 04/28/22 at 9:50am.

Refer to interview with a medication aide (MA) on 04/28/22 at 10:45am

Refer to telephone interview with Resident #3's Primary Care Provider (PCP) on 04/28/22 at 11:52am.

Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.

e. Review of Resident #3's physician's order summary report dated 03/16/22 revealed there was an order for Rivastigmine 4.6mg/24hr once daily to treat dementia with behavioral disturbances.

Review of Resident #3's April 2022 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Rivastigmine 4.6mg/24hr patch to be applied to the skin once daily at 9:00am.
-There was documentation Rivastigmine was not administered to the resident on 04/09/22 and 04/16/22 because the resident refused.
-There was no documentation Resident #3's Primary Care Provider was notified the resident refused the medication.

Review of Resident #3's March 2022 eMAR revealed:
-There was an entry for Rivastigmine 4.6mg/24h patch to be applied to the skin once daily at 9:00am.
-There was documentation Rivastigmine was not administered to the resident on 03/02/22, 03/05/22, and 03/29/22 because the resident refused the medication.
-There was no documentation Resident #3's PCP was notified the resident refused the medication.

Review of Resident #4's February 2022 eMAR revealed:
-There was an entry for Rivastigmine 4.6mg/24h patch to be applied to the skin once daily at 9:00am.
-There was documentation Rivastigmine 4.6mg/24hr patch was not administered to the resident on 02/01/22, 02/04/22, 02/06/22, 02/11/22, 02/16/22, 02/19/22, 02/21/22 to 02/23/22, and 02/25/22 because the resident refused the medication.
-There was no documentation Resident #3's PCP was notified the resident refused the medication.

Review of the facility's progress notes from 02/01/22 to 04/26/22 for Resident #3 revealed

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there was no documentation the resident's PCP was notified Rivastigmine was refused.

Refer to interview with the Administrator on 04/28/22 at 9:07am.

Refer to interview with the Area Director (AD) for 200 Hall on 04/28/22 at 9:50am.

Refer to interview with a medication aide (MA) on 04/28/22 at 10:45am

Refer to telephone interview with Resident #3's Primary Care Provider (PCP) on 04/28/22 at 11:52am.

Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.

f. Review of Resident #3's physician's order summary report dated 03/16/22 revealed there was an order for Sinemet 25-100mg administer 1.5 tablets three times daily to treat Parkinson's disease.

Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed:
-There was an electronic entry for Sinemet 25-100mg administer 1.5 tablets three times daily at 9:00am, 2:00pm, and 9:00pm.
-There was documentation Sinemet was not administered on 04/09/22 and 04/16/22 at 9:00am, 04/26/22 at 2:00pm, and 04/06/22, 04/10/22, and 04/24/22 at 9:00pm because the resident refused.
-There was no documentation Resident #3's Primary Care Provider was notified the resident refused the medication.

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D 273	Continued From page 10 Review of Resident #3's March 2022 eMAR revealed: -There was an entry for Sinemet 25-100mg administer 1.5 tablets three times daily at 9:00am, 2:00pm, and 9:00pm. -There was documentation Sinemet was not administered on 03/02/22, 03/05/22, and 03/29/22 at 9:00am and 2:00pm; 03/12/22 at 9:00am; 03/01/22, 03/03/22, 03/14/22, and 03/24/22 at 2:00pm; and 03/04/22, 03/13/22, 03/22/22 and 03/30/22 at 9:00pm because the resident refused the medication. -There was no documentation Resident #3's PCP was notified the resident refused the medication. Review of Resident #3's February 2022 eMAR revealed: -There was an entry for Sinemet 25-100mg administer 1.5 tablets three times daily at 9:00am, 2:00pm, and 9:00pm. -There was documentation Sinemet was not administered to the resident on 02/03/22 and 02/06/22 at 9:00am; 02/04/22, 02/13/22, 02/17/22, 02/19/22, and 02/24/22 at 2:00pm; 02/02/22, 02/12/22, and 02/26/22 to 02/27/22 at 9:00pm; 02/11/22, 02/16/22, 02/22/22 to 02/23/22, and 02/25/22 at 9:00am and 2:00pm; and 02/21/22 at 9:00am, 2:00pm, and 9:00pm because the resident refused the medication. -There was no documentation Resident #3's PCP was notified the resident refused the medication. Review of the facility's progress notes from 02/01/22 to 04/26/22 for Resident #3 revealed there was no documentation the resident's PCP was notified Sinemet was refused. Refer to interview with the Administrator on 04/28/22 at 9:07am.	D 273		

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D 273	Continued From page 11 Refer to interview with the Area Director (AD) for 200 Hall on 04/28/22 at 9:50am. Refer to interview with a medication aide (MA) on 04/28/22 at 10:45am Refer to telephone interview with Resident #3's Primary Care Provider (PCP) on 04/28/22 at 11:52am. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. _____ Interview with the Administrator on 04/28/22 at 9:07am revealed: -The medication aide (MA), MA/S (MA/Supervisor), or area director (AD) were responsible to notify Resident #3's Primary Care Provider (PCP) by phone or fax when the resident refused a medication three times in a row. -Resident #3's PCP had an on-call service provider that was available 24 hours a day seven days a week. -PCP notification would be documented in the resident's facility progress notes by the MA, SIC, or AD. -There was no reason Resident #3's PCP would not be notified of medication refusals. Interview with the Area Director (AD) for 200 Hall on 04/28/22 at 9:50am revealed: -Medications documented as refusal on the eMAR automatically populated in the resident's facility progress notes and the 24-hour report. -The 24-hour report was reviewed every morning by the AD assigned to the hall. -The AD assigned to the resident's hall was responsible to notify the resident's PCP of	D 273		

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continued medication refusals; such as daily, every other day, or three times a week when noting the refusal in the 24-hour report.
-She was responsible to document in the resident's progress note after notifying the resident's PCP of the medication refusal.
-She was responsible to fax the PCP or place a note of the resident and medications refusal, in the PCP's communication folder to review when she made weekly facility visits.
-The MAs were responsible to verbally report to the AD when a resident refused medications twice weekly.
-She did not know Resident #3 had refused medications.
-She was not told Resident #3 refused medications.
-She last reviewed 200 hall shift report about two days ago.
-She did not notice Resident #3 refused medications at that time.
-It was not mandatory the AD review the 24-hour report daily.

Interview with a medication aide (MA) on 04/28/22 at 10:45am revealed:
-She was responsible to document medication refusals when the resident refused the medication after three attempts.
-She was responsible to report to the AD when a resident refused medications after three attempts.
-She told the AD after a resident refused once so the AD could try to administer the medication to the resident.
-If a resident did refuse medications after three attempts, she faxed a physician notification to the PCP, attached the fax confirmation sheet to the physician notification, and submitted them both to the AD.
-Resident #3 refused medications during times

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065002	A. BUILDING: _____ B. WING _____	04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COMMONS AT BRIGHTMORE	2320 FORTY-FIRST STREET WILMINGTON, NC 28403

(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 13 she was the MA. -She did not tell the AD Resident #3 refused medications during times she was the MA. -She did not notify Resident #3's PCP the resident refused medications. -There was no reason why. Telephone interview with Resident #3's Primary Care Provider (PCP) on 04/28/22 at 11:52am revealed: -She was not notified by the facility Resident #3 refused medications in February 2022, March 2022, or April 2022. -She reviewed Resident #3's electronic on-call notes and PCP visit notes from February 2022 to April 2022 and there was no documentation of notification from the facility that Resident #3 had refused medications. -She last visited Resident #3 on 04/27/22 and was not notified by the facility Resident #3 had refused medications. -She expected the facility to notify her when Resident #3 refused medications daily or multiple days in a row.	D 273		