STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL090024	A. BUILDING: _____ B. WING _____	R 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MONROE SQUARE 1	918 FITZGERALD STREET MONROE, NC 28112

(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 and Union County Department of Social Services conducted an annual and follow-up survey on March 19, 2024-March 21, 2024.	D 000	**The following is the Plan of Correction for Brookdale Monroe Square Assisted Living regarding the Statement of Deficiencies dated March 19-21, 2024. 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 a 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 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that medications were stored securely when a medication aide left a medication cart unlocked and unattended while residents passed by or sat near the unlocked medication cart. The findings are: Review of the facility's Medication and Treatment Storage Policy with a revision date of October 2018 revealed medications and treatments are to be stored in designated locations that must be locked when not in use or when unattended. Observation of the facility on 03/21/24 from 8:04am to 8:51am revealed: -At 8:04am, a medication cart labeled cart 2B was in the hallway outside of the television/sitting room and was unlocked and unattended. -There were no staff members in the hallway near	D 378		

Reviewed and acknowledged on 04/08/24 by JL

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D 378	Continued From page 1 or at the medication cart. -The medication storage drawers on cart 2B opened and contained insulin pen needles, one plastic medicine cup that contained tablets and capsules, nail clippers, scissors, various eye drops, inhalers, oral medications, and topical medications. -The storage area for controlled substances was locked. -At 8:07am, a female resident passed by the unlocked medication cart and walked toward the dining room. -At 8:09am, a female resident passed by the unlocked medication cart and walked toward the dining room. -At 8:20am, a female resident passed by the unlocked medication cart and walked toward the dining room. -At 8:29am, a female resident passed by the unlocked medication cart and walked toward her room. -At 8:36am, a female resident passed by the unlocked medication cart and walked toward her room. -At 8:37am, a female resident passed by the unlocked medication cart and walked toward her room. -At 8:41am, two female residents passed by the unlocked medication cart and walked toward their rooms. -At 8:42am, a female resident and a male resident in a wheelchair passed by the unlocked medication cart and proceeded toward their room. -At 8:42am, a male resident in a wheelchair propelled himself past the unlocked medication cart and toward his room. -At 8:47am, a female resident and male resident passed by the unlocked medication cart and walked toward their rooms.	D 378	10A NCAC 13F .1006 Medication Storage Health and Wellness Director or designee to re-inservice medication technicians on medication storage of all prescription and non-prescription stored by the community, including those requiring refrigeration, be maintained in a safe manner under locked security except when under the immediate or direct supervision of staff in charge of medication administration. To assist with ongoing compliance, the Resident Care Coordinator, Health and Wellness Director or designee will complete spot checks, weekly for two (2) months, with the Medication Technicians to verify medications are stored and maintained appropriately.	March 22, 2024

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D 378	Continued From page 2 -At 8:49am, a female resident in a wheelchair propelled herself in her wheelchair near the unlocked medication cart and sat in her wheelchair beside the medication cart. -At 8:49am, a male resident passed by the unlocked medication cart and continued walking toward the dining room. -At 8:49am, a surveyor informed the Health and Wellness Director (HWD) the medication cart was unlocked. -At 8:50am, the HWD informed the medication aide (MA) the medication cart was unlocked . -The MA approached the medication cart and locked the medication cart at 8:51am. -A total of 15 residents passed by or were near the unlocked medication cart from 8:04am to 8:51am. Review of current FL-2 forms for 9 residents identified as passing by or near the unlocked medication cart revealed 6 of 9 residents had disorientation or a diagnosis of Alzheimer's Disease. Interview with the MA on 03/21/24 at 9:27am revealed: -She went to the dining room this morning, 03/21/24, to help serve breakfast to the residents. -She must have been distracted and forgot to lock the medication cart before she went to the dining room. -The medication cart should have been locked when she left to go to the dining room. Interview with the HWD on 03/21/24 at 9:57am revealed: -The MA assisted in the dining room during the residents' breakfast meal this morning, 03/21/24. -The MAs should always lock the medication cart when the cart was not in use.	D 378		

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D 378	Continued From page 3 -She was unsure why the medication cart was unlocked this morning, 03/21/24. -There were some residents in the facility with confusion and dementia, but she was not aware of any residents who would attempt to open the medication cart. -The medication carts needed to be locked so that residents did not access medications in the medication cart. -The medication cart being left unlocked was a concern due to the residents' safety. Interview with the Administrator on 03/21/24 at 10:02am revealed: -The MA took a resident to the dining room this morning and assisted with serving breakfast to the residents. -The MA must have been distracted and forgot to lock the medication cart. -There were some residents with dementia and confusion in the facility. -The MA should always lock the medication cart when the cart was unattended. -She was concerned that a resident could open the medication cart and access medication or something that could be harmful.	D 378		