

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL016006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/18/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE MOREHEAD CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 107 BRYAN STREET MOREHEAD CITY, NC 28557		
(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 and follow-up survey on July 16-18, 2024.	D 000	The following is the Plan of Correction for Brookdale Morehead City regarding the Statement of Deficiencies dated 7/18/24. 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. Brookdale Morehead City will ensure the Resident Register initial assessment is completed and signed by the administrator/ designee and the resident or resident's representative within 72 hours of admission. Executive Director (ED) to complete 100% audit of resident records to ensure a completed/ signed Resident Register is present. Any record noted to not have a completed Register, will be completed and reviewed with the		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Facility & 10A NCAC 13F .0704 Resident Contract, Information On Facility, And Resident Register (b) The administrator or their management designee and the resident or the resident's representative shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following: (1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address; (2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status; (3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests; (4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail; (5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D-4.8; and (6) resident's consent including a signature confirming the review and receipt of information	D 248			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

8TBH11

continuation sheet 1 of 32

Jamaal Willis

Reviewed and Acknowledged 09/24/24

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D 248	Continued From page 1 contained in the form. The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf at no charge. The facility may use a resident information form other than the Resident Register as long as it contains the same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the Resident Register was completed and signed within 72 hours of admission for 4 of 5 sampled residents (#1, #2, #3, and #4). The findings are: 1. Review of Resident #1's current FL2 dated 06/28/24 revealed: -Diagnoses included interstitial pneumonitis, hypercholesterolemia, hypertension, and gastroesophageal reflux disease. -He was ambulatory and there was no information on orientation. -The admission date was 06/21/24. Review of Resident #1's Resident Register revealed: -There was no admission date. -The signature page did not have a signature and date of the responsible person. -The signature page did not have a signature or	D 248	resident or resident representative. The Register will be signed by both parties upon completion. ED will ensure the Resident Register initial assessment is completed and signed with the resident or resident representative within 72 hours of admission to the facility.	9/1/24

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D 248	Continued From page 2 date of an Administrator. Refer to interview with the Clinical Services Supervisor on 07/17/24 at 11:35am. Refer to interview with the Health and Wellness Coordinator on 07/17/24 at 11:40am Refer to the interview with the Executive Director on 07/17/24 at 11:50am. Refer to the interview with the Business Office Manager on 07/17/24 at 12:00pm. 2. Review of Resident #2's current FL2 dated 02/18/23 revealed: -Diagnoses included hypertension, edema, and depression. -She ambulatory and constantly disoriented. -There was not an admission date. Review of Resident #2's Resident Register revealed: -There was no admission date. -The signature page did not have a signature and date of the responsible person. -The signature page did not have a signature or date of an Administrator. Refer to interview with the Clinical Services Supervisor on 07/17/24 at 11:35am. Refer to interview with the Health and Wellness Coordinator on 07/17/24 at 11:40am Refer to the interview with the Executive Director on 07/17/24 at 11:50am. Refer to the interview with the Business Office Manager on 07/17/24 at 12:00pm.	D 248			

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D 248	Continued From page 3 3. Review of Resident #3's current FL2 dated 10/24/23 revealed: -Diagnoses included Alzheimer's Disease, and osteoarthritis. -She was semi-ambulatory with a wheelchair and intermittently disoriented. -The admission date was 12/21/22. Review of Resident #3's Resident Register revealed: -There was no admission date. -The signature page did not have a signature and date of the responsible person. -The signature page did not have a signature or date of an Administrator. Refer to interview with the Clinical Services Supervisor on 07/17/24 at 11:35am. Refer to interview with the Health and Wellness Coordinator on 07/17/24 at 11:40am Refer to the interview with the Executive Director on 07/17/24 at 11:50am. Refer to the interview with the Business Office Manager on 07/17/24 at 12:00pm. 4. Review of Resident #4's current FL2 dated 04/18/24 revealed: -Diagnoses included dementia, cerebral vascular accident, and hypertension. -She was non-ambulatory and constantly disoriented. -The admission date was 04/10/23. Review of Resident #4's Resident Register revealed: -There was no admission date.	D 248			

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D 248	Continued From page 4 -The signature page did not have a signature and date of the responsible person. -The signature page did not have a signature or date of an Administrator. Refer to interview with the Clinical Services Supervisor on 07/17/24 at 11:35am. Refer to interview with the Health and Wellness Coordinator on 07/17/24 at 11:40am Refer to the interview with the Executive Director on 07/17/24 at 11:50am. Refer to the interview with the Business Office Manager on 07/17/24 at 12:00pm. Interview with the Clinical Services Supervisor on 07/17/24 at 11:35am revealed: -She and the Health and Wellness Coordinator were responsible for ensuring all paperwork for residents were complete. -Family members were given the Resident Register to complete and the Executive Director was responsible for signing and dating. Interview with the Health and Wellness Coordinator on 07/17/24 at 11:40am revealed: -She and the Clinical Services Supervisor were responsible for ensuring all paperwork for residents were complete. -The Business Office Manager was responsible for ensuring the Resident Register was completed before a resident was admitted into the facility. Interview with the Business Office Manager on 07/17/24 at 12:00pm revealed: -The Executive Director gave the admission	D 248			

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D 248	Continued From page 5 paperwork which including the Resident Register to the family. -She was responsible for getting the admission paperwork from the family and checking it for completion. -She was responsible for giving the completed Resident Register to the Executive Director to sign. -She was not aware the Executive Director had not signed and dated the Resident Registers. Interview with the Executive Director on 07/17/24 at 11:50pm revealed: -She was responsible for completing admission paperwork for residents along with the Clinical Services Supervisor and the Health and Wellness Coordinator. -She gave the admission paperwork which included the Resident Register to the families to complete. -The Business Office Manager received the Resident Registers from the families and reviewed them for completion. -She was then given the Resident Register to sign and date. -She was not aware that the Resident Registers did not have admission dates and were not signed and dated.	D 248		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by:	D 310	Brookdale Morehead City shall ensure therapeutic diets, including supplements and thickened liquids, are served as ordered by the residents' physician. Dietary Manager will in-service Cooks	

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D 310	Continued From page 6 Based on observations, record review, and interviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 2 sampled residents (#3) with a pureed diet order. The findings are: Review of Resident #3's current FL-2 dated 10/24/23 revealed: -Diagnoses included Alzheimer's disease, and osteoarthritis. -There was an order for a pureed diet. Review of Resident #3's diet order sheet dated 09/19/23 revealed: -The pureed diet was the regular diet modified to meet pureed standards. -The pureed diet order sheet was signed by the physician on 09/19/23. Observations during the initial kitchen tour on 07/16/24 at 9:17am revealed: -There was a resident nutrition report posted on the wall. -Resident #3 was listed on the nutrition report as requiring a pureed diet (should look like mashed potatoes). Observation of breakfast service for Resident #3 on 07/17/24 at 8:30am revealed: -Eggs, bacon, toast, cheese grits, raisin bran and bananas were on the menu. -Resident # 3's plate consisted of chopped banana, pureed sausage patty, and a half slice of white bread. -She ate the majority of her food. Review of the daily diet modification summary report revealed: -There was a pureed diet modification menu for	D 310	on the importance of serving diets as ordered, as well as how to find the special instructions in the recipes for mechanically altered diets. Health and Wellness Director (HWD) 9/1/24 advised clinical staff on the importance of ensuring residents receive accurate diets per physician's orders. Clinical staff should notify leadership if discrepancies are noted with a resident's therapeutic diet. Resident diets reviewed and verified 9/1/24 for accuracy by the Clinical Leadership Team. Updated copy of diets provided to Dietary team to ensure needed information is available. Dietary Manager will train newly hired 9/1/24 cooks to understand "special diet instructions", and the importance of following MD orders for diets, thickened liquids, and supplements. Clinical Leadership Team/ Dietary 9/1/24 Manager will orient newly hired clinical staff to therapeutic diets and thickened liquids, as well as which residents require these special items. Management Team will make random 9/1/24 rounds in the dining room at meal times to ensure meal service occurs as appropriate.	9/1/24

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D 310	Continued From page 7 breakfast on 07/17/24. -Pureed diet menu consisted of pureed breakfast entree, omit bacon pureed sausage patty, pureed bread, peel and pureed banana, and omit raisin bran, substitute cream of wheat. Observation of lunch service for Resident #3 on 07/17/24 at 12:00pm revealed: -Beet salad, baked ham, macaroni and cheese, steamed vegetables and blueberry crisp were on the menu. -Resident #3's plate consisted of pureed fruit and beets, pureed ham and macaroni and cheese, slice of white bread cut in half and blueberry crisp. -She ate the majority of her food. Review of the daily diet modification summary report revealed: -There was a pureed diet modification menu for lunch on 07/17/24. -Puree diet menu consisted of pureed chilled salad, pureed ham, pureed vegetables, pureed bread, and pureed blueberry crisp. Interview with the MA who served Resident #3 her plate during lunch service on 07/17/24 at 3:15pm revealed: -Resident #3 was on a pureed diet. -Kitchen staff prepared food, plated food and sent the plates to the memory care unit on a food cart. -Resident #3's meals were pureed, but she got whole dinner rolls, and sliced bread with her meals. Interview with the Dining Services Manager on 07/17/24 at 3:20pm revealed: -Resident #3 was on the resident nutrition report as a pureed diet. -She had a daily diet modification menu to follow.	D 310			

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D 310	Continued From page 8 -Resident #3 loved bread so she gave her dinner rolls, bread, toast and grilled cheese sandwiches. -She should have followed the diet modification menu and pureed the bread and all other items and omitted toast and dinner rolls from Resident #3's diet. -It was the kitchen staff's responsibility to prepare all therapeutic diets. -The previous Dining Services Manager gave Resident #3 bread, toast, and dinner rolls so she continued to do so. Interview with the Executive Director on 07/17/24 at 4:05pm revealed: -The kitchen staff had a modified diet list. -The kitchen staff had a daily diet modification menu to follow. -It was the kitchen staff's responsibility to prepare all therapeutic diets. -She expected kitchen staff to follow the diets as prescribed by the physician. -Resident #3 should have had her food pureed as the menu specified. Attempted telephone interview with Resident #3's primary care provider (PCP) on 7/17/24 at 9:55am was unsuccessful.	D 310			
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	D 358	Brookdale Morehead City shall ensure that the preparation and administration of medications and treatments by staff are according to orders by a prescribing provider, which are maintained in the Resident's record; the facility's policies and procedures; and the rules of section .1004(a).		

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D 358	Continued From page 9 and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered to 3 of 5 residents (#2, #5, #8) observed during the medication pass including errors with a medication used to reduce the risk of heart attacks, strokes, or blood clots (#2), a medication used to treat mild to moderate pain, a medication used to treat anxiety (#5), a medication used to treat high blood pressure and a medication used to treat anxiety (#8). The findings are: The medication error rate was 19% as evidenced by the observation of 5 errors out of 26 opportunities during the morning medication passes on 07/16/24. 1. Review of Resident #5's current FL-2 dated 04/24/24 revealed diagnoses included hypertension, disc degeneration of lumbar and sacral, osteoarthritis, depression, polyneuropathy, gastroesophageal reflux disease, and urinary tract infections. Interview with the facility's contracted pharmacy's pharmacy technician on 07/17/24 at 4:25pm revealed: -The prescriptions were sent directly from the providers to the pharmacy. -There was a prescription dated 05/14/24 for Valium 2mg three times daily for 5 days, 15 tablets for Resident #5. -There was a prescription dated 05/22/24 and 07/16/24 from another provider for Valium 2mg	D 358	Clinical Leadership Team in-serviced the Med Techs on the 7 Rights of Medication Administration; the importance of administering meds within the proper timeframe; notifying management if a resident misses their medications; and the importance of keeping the med carts locked when not in direct use. Med Techs were re-educated on proper diabetic care, including finger stick blood sugars and insulin administration; the importance of having ordered medications on hand, and ensuring medications are administered per MD orders. Clinical Leadership Team to complete 100% cart audit as a baseline to ensure accurate meds on hand, no expired meds on cart, and any discontinued meds removed from the cart. Medication errors will be processed per policy, and documented appropriately by the Clinical Leadership Team with ED notification. Clinical Leadership Team/ Designee will complete weekly med cart/ med room audits to ensure accuracy and availability of ordered meds. Documentation of Cart audits will be verified by HWD and ED upon completion. Medications will be reordered as required.	7/24/24 7/24/24 9/1/24 9/1/24 9/1/24

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D 358	Continued From page 10 three times daily and each was filled for a 30-day supply of 90 tablets each for Resident #5. Observation of the morning medication pass on 07/16/24 revealed Valium 2mg was administered to Resident #5 at 11:10am when she received her other morning medications. Review of Resident #5's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Valium 2mg three times daily until 05/21/24 scheduled at 8:00am, 12:00pm, and 4:00pm. -Valium 2mg was documented as administered 05/16/24-05/21/24 at 8:00am. -Valium 2mg was documented as administered 05/16/24-05/18/24 and 05/20/24 at 12:00pm. -On 05/19/24, there was an "03" above the medication aides (MA) initials at 12:00pm, which indicated she was out of the facility. -On 05/21/24, there was an "09" above the MA's initials at 12:00pm, which indicated "other" and to refer to the resident's progress notes. -Valium 2mg was documented as administered 05/16/24-05/20/24 at 4:00pm. -On 05/21/24, there was an "09" above the MA's initials at 4:00pm, which indicated "other" and to refer to the resident's progress notes. -Valium 2mg was not documented as administered on 05/22/24 to 05/31/24. Review of Resident #5's progress notes dated 05/19/24 and 05/21/24 revealed that she was out of the facility when Valium 2mg was due to be administered at 12:00pm and 4:00pm. Review of Resident #5's June 2024 eMAR revealed there was not an entry for Valium 2mg three times daily.	D 358	New Order Tracking Tool will be consistently utilized by the clinical team to ensure new orders are processed promptly and properly; this includes HWD verification of the accuracy of medication orders entered into the EMAR system. Once all steps on the tool have been completed and accuracy verified, it will be stored in a Binder housed with the HWD for referral if required. Clinical Leadership Team will complete random Med Tech Observations during Med Passes to ensure compliance with proper medication administration.	9/1/24	9/1/24

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STREET ADDRESS, CITY, STATE, ZIP CODE

BROOKDALE MOREHEAD CITY

107 BRYAN STREET

MOREHEAD CITY, NC 28557

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D 358	Continued From page 11 Review of Resident #5's July 2024 eMAR revealed: -There was an entry for Valium 2mg three daily scheduled at 8:00am, 12:00pm, and 4:00pm. -Valium 2mg was documented as administered on 07/16/24-07/17/24 at 8:00am. -Valium 2mg was documented as administered on 07/15/24-07/16/24 at 12:00pm. -Valium 2mg was documented as administered on 07/15/24-07/16/24 at 4:00pm. -Valium 2mg was not documented as administered 07/01/24 to 07/14/24. Observation of Resident #5's medications on hand on 07/17/24 at 3:00pm revealed: -There were 3 medication cards of Valium 2mg that was dispensed on 05/22/24 with 30 tablets on each card, one card contained 25 tablets, one card contained 29 tablets, and one card contained 30 tablets. -There was 3 medication cards of Valium 2mg that was dispensed on 07/16/24 with 30 tablets on each card, all three cards contained 30 tablets each. Interview with Resident #5 on 07/17/24 at 10:10am and 4:15pm revealed: -Her medications were administered late regularly. -The morning medications were administered after breakfast and sometime before lunch. -She slept most of the day and did not have the energy to do anything. -She had to steady herself when she stood up using her walker. -She did not attend activities because she was too sleepy. -She had fallen several times since she had been at the facility.	D 358		

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(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 358	Continued From page 12 Telephone interview with the facility's contracted pharmacist on 07/17/24 at 9:25am revealed: -Administering the medication too close together was concerning. -Resident #5's anxiety in the morning could increase. -There could be an increase in Resident #5's drowsiness, increased lethargy, increased sedation, and her fall risk would increase when the medication was administered too close together. -She was not sure why Resident #5's Valium was scheduled at 8:00am, 12:00pm, and 4:00pm. -The pharmacy recommended scheduling medication to be administered three times a day at 8:00am, 2:00pm, and 8:00pm. -The pharmacy was not responsible for entered orders in the facility's eMAR. -The facility was responsible for entering orders and medication times in their eMAR system. Telephone interview with the facility's contracted pharmacist on 07/17/24 at 3:45pm revealed: -Valium remained in the system much longer than other anti-anxiety medications of its class. -Oral Valium reached its peak 8 to 12 hours after administration. -She was concerned about the timing of the administration of Resident #5's Valium because it decreased the efficacy of the drug if it was not being administered consistently. Interview with the Health Wellness Coordinator (HWC) on 07/17/24 at 9:00am revealed: -She was responsible for entering new orders into the eMAR when she was working, and the MAs entered orders after hours and on weekends. -There was an order tracking system that the staff entering the orders would complete and place in	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL016006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/18/2024
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D 358	Continued From page 13 the medication room and she verified that the orders were correct, and the Health and Wellness Director (HWD) checked orders that she entered. -She entered Valium 2mg three times daily into the eMAR for 8:00am, 12:00pm, and 4:00pm. -The eMAR system's only option for three times daily were 8:00am, 12:00pm, and 4:00pm. Interview with the Regional Clinical Service Specialist on 07/17/24 at 11:20am revealed the eMAR system was preprogrammed for three times daily. Attempted telephone interview with Resident #5's primary care provider (PCP) on 07/17/24 at 9:55am and 4:00pm was unsuccessful. Refer to interview with the MA on 07/17/24 at 8:00am. Refer to interview with the Health Wellness Coordinator (HWC) on 07/17/24 at 9:00am. Refer to interview with the Regional Clinical Service Specialist on 07/17/24 at 11:20am. Refer to interview with the Administrator on 07/17/24 at 10:55am. b. Review of Resident #5's primary care provider (PCP) order sheet dated 07/02/24 revealed an order for Celecoxib 200mg twice daily (Celecoxib is used to treat mild to moderate pain). Observation of the morning medication pass on 07/16/24 revealed Celecoxib 200mg was administered at 11:10am when she received her other medications. Review of Resident #5's July 2024 eMAR revealed: -There was an entry for Celecoxib 200mg twice	D 358		

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D 358	Continued From page 14 daily, scheduled for 8:00am and 9:00pm. -Celecoxib 200mg was documented as administered 07/01/24-07/17/24 at 8:00am. -Celecoxib 200mg was documented as administered 07/01/24-07/16/24 at 9:00pm. Observation of Resident #5's medications on hand on 07/17/24 at 3:00pm revealed there were two bottles of Celecoxib 200mg dated 04/02/24 and 6/24/24. Interview with Resident #5 on 07/17/24 at 10:10am and 4:15pm revealed her pain was a 10 out of 10 in the morning and 5 out of 10 at dinner time. Telephone interview with the facility's contracted pharmacist on 07/17/24 at 9:25am revealed Resident #5 could have increased pain during the morning because her Celecoxib 200mg was administered late. Attempted telephone interview with Resident #5's primary care provider (PCP) on 07/17/24 at 9:55am and 4:00pm was unsuccessful. Refer to interview with the MA on 07/17/24 at 8:00am. Refer to interview with the Health Wellness Coordinator (HWC) on 07/17/24 at 9:00am. Refer to interview with the Regional Clinical Service Specialist on 07/17/24 at 11:20am. Refer to interview with the Administrator on 07/17/24 at 10:55am. 2. Review of Resident #8's current FL-2 dated 10/24/23 revealed diagnoses included hypertension diabetes, stroke, mixed lipidemia, osteopenia, Lewy body dementia, and	D 358			

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D 358	Continued From page 15 incontinence. a. Review of Resident #8's current primary care provider (PCP) order sheet dated 07/05/24 revealed an order for Metoprolol Succinate ER 25mg twice daily (used to treat high blood pressure). Observation of the morning medication pass on 07/16/24 revealed that Metoprolol Succinate ER 25mg was administered at 10:49am when she received her other medications. Review of Resident #8's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Metoprolol Succinate ER 25mg twice daily, scheduled at 8:00am and 8:00pm. -Metoprolol Succinate ER 25mg was documented as administered on 07/01/24-07/16/24 at 8:00am. -Metoprolol Succinate ER 25mg was documented as administered on 07/01/24-07/15/24 at 8:00pm. Telephone interview with the facility's contracted pharmacist on 07/17/24 at 9:25am revealed: -Resident #8's Metoprolol Succinate should be administered 12 hours apart due to it being sustained release. -If Metoprolol Succinate was administered too close together there could be periods of time when the resident could have more medication in their system which could cause a decrease in the blood pressure. -If Metoprolol Succinate was administered too far apart there would be periods of time when the resident would have less medication in their system which could cause an elevation in the blood pressure.	D 358			

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D 358	Continued From page 16 Interview with Resident #8 on 07/17/24 at 10:00am revealed: -She occasionally had a headache in the morning. -Her headache this morning was a 7 out of 10. Attempted telephone interview with Resident #8's primary care provider (PCP) on 07/17/24 at 9:40am was unsuccessful. Refer to interview with the MA on 07/17/24 at 8:00am. Refer to interview with the Health Wellness Coordinator (HWC) on 07/17/24 at 9:00am. Refer to interview with the Regional Clinical Service Specialist on 07/17/24 at 11:20am. Refer to interview with the Administrator on 07/17/24 at 10:55am. b. Review of Resident #8's current primary care provider (PCP) order sheet dated 07/05/24 revealed an order for Risperidone 2mg administer half a tablet twice daily (1mg) (used to treat anxiety and dementia). Observation of the morning medication pass on 07/16/24 revealed that Risperidone 2mg (half tablet) was administered at 10:49am when she received her other medications. Review of Resident #8's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Risperidone 2mg administer half a tablet twice daily (1mg), scheduled at 8:00am and 8:00pm. -Risperidone 2mg (half tablet) was documented as administered on 07/01/24-07/16/24 at 8:00am. -Risperidone 2mg (half tablet) was documented as administered on 07/01/24-07/15/24 at 8:00pm.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL016006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/18/2024
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D 358	Continued From page 17 Telephone interview with the facility's contracted pharmacist on 07/17/24 at 9:25am revealed: -Risperidone 1mg should be administered 12 hours apart. -Risperidone 1mg could cause increased drowsiness and increase the risk of falls if administered too close together. Interview with Resident #8 on 07/17/24 at 10:00am revealed: -Her medications were administered late frequently. -Her medications were always administered after breakfast and usually before lunch. Attempted telephone interview with Resident #8's primary care provider (PCP) on 07/17/24 at 9:40am was unsuccessful. Refer to interview with the MA on 07/17/24 at 8:00am. Refer to interview with the Health Wellness Coordinator (HWC) on 07/17/24 at 9:00am. Refer to interview with the Regional Clinical Service Specialist on 07/17/24 at 11:20am. Refer to interview with the Administrator on 07/17/24 at 10:55am. 3. Review of Resident #2's current FL-2 dated 12/18/23 revealed diagnoses included hypertension, depression, ataxia, memory deficit, stroke, Vitamin D deficiency, and edema. Review of Resident #2's current primary care provider (PCP) order sheet dated 07/05/24 revealed an order for Aspirin 325mg once daily (used to reduce the risk of heart attacks, stroke, or blood clots).	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL016006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/18/2024
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D 358	Continued From page 18 Observation of the morning medication pass on 07/16/24 revealed Aspirin 81mg was administered to Resident #2 at 9:17am when she received her other medications. Observation of Resident #2's medications on hand on 07/17/24 at 3:00pm revealed there was a bottle of Aspirin 81mg. Review of Resident #2's July 2024 eMAR revealed: -There was an entry for Aspirin 325mg once daily at 9:00am. -Aspirin 325mg was documented as administered at 9:00am on 07/01/24-07/16/24. Telephone interview with the facility's contracted pharmacist on 07/17/24 at 9:25am revealed they had never received a prescription for Aspirin 325mg or 81mg for Resident #2. Interview with a MA on 07/17/24 at 8:00am revealed: -She compared all medications to the eMAR before administering. -She had been educated to compare the eMAR to the medication before administering. -She was not sure why she had not noticed the difference in that the eMAR order for Aspirin 325mg was not the same as the Aspirin 81mg she was administering. Interview with the HWC on 07/17/24 at 9:00am revealed: -She was responsible for entering new orders into the eMAR when she was working, and the MAs entered orders after hours and on weekends. -There was an order tracking system that the staff entering the orders would complete and place in the medication room and she verified that the	D 358			

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D 358	Continued From page 19 orders were correct, and the Health and Wellness Director (HWD) checked orders that she entered. -Resident #2's over the counter Aspirin was provided by the resident's family. -She was not sure why the Aspirin was not compared to the order before placing it on medication cart. Interview with the Regional Clinical Service Specialist on 07/17/24 at 11:20am revealed the staff had been recently educated on the process of comparing medications to the eMARs before administering. Interview with the Administrator on 07/17/24 at 10:55am revealed: -The MAs should be comparing the medications to the orders before administering. -There was a refresher training provided to all MAs in January 2024 and March 2024, medication administration was covered in detail. Telephone interview with Resident #2's primary care provider (PCP) on 07/17/24 at 9:45am revealed she was concerned that Aspirin was not administered as ordered. Interview with the MA on 07/17/24 at 8:00am revealed: -She had been educated to inform the Health Wellness Coordinator (HWC) and the Health Wellness Director (HWD) when medications were administered late. -She did not inform the Health Wellness Coordinator (HWC) on 07/16/24 that she was late passing medications. -She was not allowed to pass medications during meals because she was helping in the dining room.	D 358			

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D 358	Continued From page 20 Interview with the Health Wellness Coordinator (HWC) on 07/17/27 at 9:00am revealed: -MAs should notify management when medications were passed late. -She did not know that medications were passed late on 07/16/24. Interview with the Regional Clinical Service Specialist on 07/17/24 at 11:20am revealed: -MAs should document when they administer medications late and let the HWC and HWD know. -She was not notified that medications were administered late on 07/16/24. -She had educated the MAs on the process when late medications were administered. Interview with the Administrator on 07/17/24 at 10:55am revealed: -She did not know medications were administered late on 07/16/24. -MAs had been educated to inform the HWC and HWD when medications were administered late. -The pharmacy provided a refresher on administering medication in January 2024 and March 2024. The facility failed to administer medications as ordered to Resident #5 who was prescribed Valium 2mg three times daily for anxiety scheduled at 8:00am, 12pm, and 4pm. The 8:00am dose was administered at 11:10am and her 12:00pm dose was documented as administered. Receiving the two doses that close together could increase fall risk, increase sedation, increase drowsiness, and cause lethargy. Resident #5 received her pain medication 1 hour and 55 minutes late and the resident reported experiencing a 10 out of 10 on the pain scale in the morning. This failure was	D 358			

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STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL016006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/18/2024
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D 367	Continued From page 22 reviews the facility failed to ensure the medication administration records were accurate for 2 of 5 sampled residents (#2, #5) including a medication used to reduce the risk of heart attacks, strokes, or blood clots (#2) and a medication used to treat anxiety (#5). 1. Review of Resident #2's current FL-2 dated 12/18/23 revealed diagnoses included hypertension, ataxia, cerebral vascular accident non stemi myocardial infarction, depression, Vitamin D deficiency, and memory deficit. Review of Resident #2's physician order sheet dated 07/05/24 revealed an order for Aspirin 325mg once daily (a medication used to reduce the risk of heart attack, stroke, or blood clots). Observation of Resident #2's medications on hand on 07/07/24 at 3:00pm revealed there was a bottle of Aspirin 81mg on the medication cart. Review of Resident #2's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 325mg once daily at 9:00am. -Aspirin 325mg was documented as administered at 9:00am on 05/01/24-05/31/24. Review of Resident #2's June 2024 eMAR revealed: -There was an entry for Aspirin 325mg once daily at 9:00am. -Aspirin 325mg was documented as administered at 9:00am on 06/01/24-06/30/24. Review of Resident #2's July 2024 eMAR revealed: -There was an entry for Aspirin 325mg once daily	D 367	New Order Tracking Tool will be consistently utilized by the clinical team to ensure new orders are processed promptly and properly; this includes HWD verification of the accuracy of medication orders entered into the EMAR system. Once all steps on the tool have been completed and accuracy verified, it will be stored in a Binder housed with the HWD for referral if required. Clinical Leadership Team or Designee will conduct weekly med cart/ med room audits. Any noted concerns will be discussed with the ED to ensure proper interventions are in place.	9/1/24 9/1/24

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D 367	Continued From page 23 at 9:00am. -Aspirin 325mg was documented as administered at 9:00am on 07/01/24-07/16/24. Interview with a medication aide (MA) on 07/17/24 at 8:00am revealed: -She compared all medications to the eMAR before administering. -She had been educated to compare the eMAR to the medication before administering. -She was not sure why she had not noticed the difference in what the eMAR order for Aspirin 325mg was not the same as the Aspirin 81mg she was administering. Interview with the Health and Wellness Coordinator (HWC) on 07/17/24 at 9:00am revealed: -She was responsible for entering new orders onto the eMAR when she was working, and the MAs entered orders after hours and on weekends. -There was an order tracking system that the staff entering the orders would complete and place in the medication room and she verified that the orders were correct, and the Health and Wellness Director (HWD) checked orders that she entered. 2. Review of Resident #5's current FL-2 dated 04/24/24 revealed diagnoses included hypertension, disc degeneration of lumbar and sacral, osteoarthritis, depression polyneuropathy, gastroesophageal reflux disease, urinary tract infections. Interview with the facility's contracted pharmacy's pharmacy technician on 07/17/24 revealed: -There was a prescription dated 05/14/24 for Valium 2mg three times daily for 5 days, 15 tablets.	D 367			

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D 367	Continued From page 24 -There was a prescription dated 05/22/24 and 07/16/24 from another provider for Valium 2mg three times daily each was filled for a 30-day supply of 90 tablets each. Review of Resident #5's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Valium 2mg three times daily until 05/21/24 scheduled at 8:00am, 12:00pm, and 4:00pm. -Valium 2mg was documented as administered 05/16/24-05/21/24 at 8:00am. -Valium 2mg was documented as administered 05/16/24-05/18/24 and 05/20/24 at 12:00pm. -On 05/19/24, there was an "03" above the medication aides (MA) initials at 12:00pm, which indicated she was out of the facility. -On 05/21/24, there was an "09" above the MA's initials at 12:00pm, which indicated "other" and to refer to the resident's progress notes. -Valium 2mg was documented as administered 05/16/24-05/20/24 at 4:00pm. -On 05/21/24, there was an "09" above the MA's initials at 4:00pm, which indicated "other" and to refer to the resident's progress notes. -There was no entry for Valium 2mg three times daily from 05/22/24 to 05/31/24. Review of Resident #5's progress notes dated 05/19/24 and 05/21/24 revealed that she was out of the facility when Valium 2mg was due to be administered at 12:00pm and 4:00pm. Review of Resident #5's June 2024 eMAR revealed there was no entry for Valium 2mg three times daily. Review of Resident #5's July 2024 eMAR revealed:	D 367			

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D 367	Continued From page 25 -There was an entry for Valium 2mg three daily scheduled at 8:00am, 12:00pm, and 4:00pm. -Valium 2mg was documented as administered on 07/16/24-07/17/24 at 8:00am. -Valium 2mg was documented as administered on 07/15/24-07/16/24 at 12:00pm. -Valium 2mg was documented as administered on 07/15/24-07/16/24 at 4:00pm. -There was no entry for Valium 2mg three times daily from 07/01/24 to 07/14/24. Interview with the Health and Wellness Coordinator (HWC) on 07/17/24 at 9:00am revealed: -She was responsible for entering new orders onto the eMAR when she was working, and the MAs entered orders after hours and on weekends. -There was an order tracking system that the staff entering the orders would complete and place in the medication room and she verified that the orders were correct, and the Health and Wellness Director (HWD) checked orders that she entered.	D 367			
D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were stored in a safe and secure manner in accordance with the facility's policies and procedures for 3 of 4 resident's sampled (#1, #9,	D 377	Brookdale Morehead City shall ensure that medications that are self-administered and stored in the resident's room will be stored in a safe and secure manner. Clinical Leadership Team in-serviced 7/24/24 Med Techs on appropriate storage of resident medications that self-administer. This includes reminding the resident that their door must remain locked to their apartments if they are not present. Also, any narcotics should		

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D 377	Continued From page 26 and #10) who self-administered medications. The findings are: Review of the facility's Medication Storage Policies and Procedures dated of 3/2006 revealed: -Residents who self-administer their own medications may store and secure their non-controlled medications in their apartments by locking the apartment door each time upon departure. -Residents who self-administer their own medications should store their controlled medications in a locked drawer or cabinet so they are not accessible to others. 1. Review of Resident #9's current FL2 dated 06/28/24 revealed: -Diagnosis including hypertension, frequent falls, and hypothyroidism. -She was ambulatory and there was no information on orientation. -The admission date was 10/13/23. -She had an order to self-administer medications. Observation of Resident #9's room on the assisted living (AL) side of the facility on 07/16/24 at 12:25pm revealed: -Her door was ajar and she was not in her room. -There was a basket on the counter containing medications. -The basket contained the following medications: acetaminophen 500mg (used to treat moderate pain), vitamin E 450mg (used to support antioxidant health), premium saline nasal spray (used to treat dry and irritated nose), zinc 10mg (used as a dietary supplement), hydrochlorothiazide 12.5mg (used to treat allergic conditions), levothyroxine 75mcg (used to treat	D 377	be stored in a lock box with the door of the resident's apartment locked if they are not present. Staff re-educated on the importance of making safety rounds to ensure resident doors are locked as appropriate. Management Team will make facility rounds no less than twice daily to safe medication storage practices. If any concerns are noted, resident will be re-educated as well as staff. Door will be promptly locked. ED will provide an in-service to new admit residents that plan to self administer their medications, to ensure they understand the safety requirements for medication storage in their apartment.	7/24/24	9/1/24

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D 377	Continued From page 27 an underactive thyroid gland), and verapamil 120mg (used to treat high blood pressure), Interview with Resident #2 on 07/16/24 at 2:20:pm revealed: -She stored her medications on the counter in her bedroom. -She did not lock her door when she left her bedroom. Refer to interview with a Medication Aide (MA) on 07/18/24 at 9:45am Refer to interview with the Clinical Services Supervisor (CSS) on 07/18/24 at 9:55am. Refer to interview with the Health and Wellness Coordinator (HWC) on 07/18/24 at 10:05am Refer to the interview with the Executive Director (ED) on 07/18/24 at 10:40am. 2. Review of Resident #10's current FL2 dated 06/25/24 revealed: -Diagnosis including hypertension, gastroesophageal reflux disease, and depression. -She was ambulatory and there was no information on orientation. -The admission date was 07/08/24. -She had an order to self-administer medications. Observation of Resident #10's room on the assisted living (AL) side of the facility on 07/16/24 at 12:35pm revealed: -Her door was unlocked and she was not in her room. -Her medications were in a basket on the nightstand next to the bed. -She had the following medications: aspirin 81mg (used to treat aches and pains), B12 1000mcg	D 377			

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D 377	Continued From page 28 (used to keep blood and nerve cells healthy), sertraline hydroxide 100mg (used to treat depression), meloxicam 15mg (used to treat pain caused by osteoarthritis), omeprazole 20mg (used to treat gastroesophageal reflux disease), and atorvastatin 80mg (used to treat high cholesterol). Refer to interview with a Medication Aide (MA) on 07/18/24 at 9:45am Refer to interview with the Clinical Services Supervisor (CSS) on 07/18/24 at 9:55am. Refer to interview with the Health and Wellness Coordinator (HWC) on 07/18/24 at 10:05am Refer to the interview with the Executive Director (ED) on 07/18/24 at 10:40am. 3. Review of Resident #1's current FL-2 dated 02/29/24 revealed: -Diagnosis included interstitial pneumonitis, hypercholesterolemia, hypertension, and gastroesophageal reflux disease. -He was ambulatory and there was no information on orientation. -The admission date was 06/21/24. -He had an order to self-administer medications. Observation of Resident #1's room on the assisted living (AL) side of the facility on 07/17/24 at 3:40pm revealed: -His door was ajar. -He was asleep in his bedroom. -There was a lock box on his dresser, the key to the lockbox was inside the lock and it was unlocked. -The lockbox contained the following medications: metoprolol succinate 25mg (used	D 377			

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D 377	Continued From page 29 to treat high blood pressure), amlodipine besylate 5mg (used to treat high blood pressure), atorvastatin calcium 40mg (used to treat high cholesterol), cell cept 500mg (used to prevent rejection in people who have received an organ transplant), docusate sodium 100mg (used to treat constipation), magnesium glycinate 100mg (used to relieve anxiety), omeprazole 20mg (used to treat gastroesophageal reflux disease), and vitamin D3 50mcg (used for healthy bones). Interview with Resident #1 on 07/17/24 at 3:45pm revealed: -He did not lock his door when he left his bedroom. -He left his lockbox on the counter and the key in the lock when he left his bedroom. Refer to interview with a Medication Aide (MA) on 07/18/24 at 9:45am Refer to interview with the Clinical Services Supervisor (CSS) on 07/18/24 at 9:55am. Refer to interview with the Health and Wellness Coordinator (HWC) on 07/18/24 at 10:05am Refer to the interview with the Executive Director (ED) on 07/18/24 at 10:40am. Interview with a medication aide (MA) on 07/18/24 at 9:45am revealed: -The residents that administered their own medications were supposed to keep their doors closed and locked when they left their rooms. -Residents that self-administered medications needed to keep their doors locked so that other residents could not have access to their medication.	D 377			

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D 377	Continued From page 30 -There was a concern that a resident could get sick or die if they took medications from another resident room. Interview with the Clinical Services Supervisor (CSS) on 07/18/24 at 9:55am revealed: -All residents that administered their own medications were supposed to have a lockbox and lock their doors when not in their room. -Residents who stored their medications in their room caused safety concerns if they did not lock their medications up properly. -If a resident did not store their medications properly it could be detrimental to other residents who could get very sick if they took medications that were not prescribed to them. -There was a lack of staff members not following up to ensure residents who self-medicated locked up their medications properly. Interview with the Health and Wellness Coordinator (HWC) on 07/18/24 at 10:05am revealed: -Residents that administered their own medications had to keep their medications securely secured. -Medications that were not narcotics needed to be secured behind a locked door when a resident left their room. -Medications must be secured for safety purposes because another resident or someone visiting the facility could have gotten a hold of unsecure medications. -Lack of all staff members checking to ensure residents stored their medications properly was the reason medications were not properly secure. Interview with the Executive Director (ED) on 07/18/24 at 10:40pm revealed: -The facility's policy for storage of	D 377			

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D 377	Continued From page 31 self-administered medications was medications should be locked in the resident's room, and narcotics should be double locked in a lock box and a locked door. -The self-administered medications should not be accessible to other residents or staff. -If medications were not properly secured there would be a concern with someone going into a room and gaining access to medications. -Staff needed to reeducate residents who administer their own medications on how to properly secure their medications.	D 377			