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D 000	Initial Comments The Adult Care Liscensure Section conducted a follow-up survey on October 02, 2024 and October 3, 2024.	D 000		
D 235	10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 1 of 5 sampled residents (#5) had a FL-2 completed annually. The findings are:	D 235		

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Review of Resident #5' s FL-2 dated 09/09/23 revealed:
-Diagnoses included atrial fibrillation, transient ischemic attacks, urinary incontinence, vertigo, essential tremor, pacemaker, anxiety, and recurrent urinary tract infections.
-She was intermittently disoriented.

Review of Resident #5's record revealed Resident #5 did not have an updated FL-2 completed since 09/09/23.

Interview with the Health and Wellness Coordinator (HWC) on 10/03/24 at 11:10am revealed:
-She started work at the facility in May 2024.
-The Health and Wellness Director (HWD) was responsible for completing FL-2s.
-She had not completed an FL-2.
-She had not been trained to complete FL-2s.
-She did not know how the facility kept up with what resident was due to have their FL-2 completed.

Interview with the Health and Wellness Director (HWD) on 10/03/24 at 10:45am revealed:
-She started work at the facility in May 2024.
-She used the compliance tracker on their computer to tract when an FL-2 was due.
-She ran a report weekly from the compliance tracker to see what residents needed their FL-2 updated.
-She had not completed Resident #5's FL-2 because they were short staffed and she did not have time to complete the FL-2.
-The residents were to have a completed FL-2 signed by the primary care provider (PCP) upon admission and yearly.
-She had not performed any chart audits.

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D 235	Continued From page 2 Interview with the Interim Administrator on 10/03/24 at 2:45pm revealed: -She did not know that Resident #5's FL-2 was not completed when it was due. -The HWD and HWC were responsible for completing the FL2s then send them to the provider for signatures, and file them in the resident's chart. -Chart audits were performed by the HWD and HWC but she was not sure when the last audit was performed. -Chart audits were performed by the Area Nurse Manager (ANM) quarterly and she was not sure when the last audit was completed. -The facility used a compliance tracker to keep up with resident's documents due dates. -She was ultimately responsible to ensure the FL-2s were competed on time. -She expected each resident to have a current FL-2.	D 235		
D 262	10A NCAC 13F .0802 (d) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (d) The assessor shall sign the care plan upon its completion. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 1 of 5 sampled residents (#5) had accurate care plans signed by the assessor upon completion. The findings are: Review of Resident #5's most current FL-2 dated 09/09/23 revealed diagnoses included atrial fibrillation, transient ischemic attacks, urinary	D 262		

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incontinence, vertigo, essential tremor, pacemaker, anxiety, and recurrent urinary tract infections.

Review of Resident #5's Resident Register revealed she was admitted on 09/13/24.

Review of Resident #5's record revealed that Resident #5 had a completed care plan dated 03/20/24 that was not signed by the assessor.

Interview with the Health and Wellness Coordinator (HWC)on 10/03/24 at 11:10am revealed:
-She started work at the facility in May 2024.
-The Health and Wellness Director (HWD) was responsible for completing care plans.
-She had not completed a care plan.
-She had not been trained to complete care plans.
-She did not know how the facility kept up with what resident was due to have their care plan completed.

Interview with the HWD on 10/03/24 at 10:45am revealed:
-She started work at the facility in May 2024.
-She was responsible for completing care plans.
-She did not know why Resident #5 did not have a completed and signed care plan in her chart.
-She used the compliance tracker on their computer to tract when a care plan was due.
-She ran a report weekly from the compliance tracker to see what residents needed their care plan updated.
-The compliance tracker did not show that there were any care plans due to be updated.
-She had not performed any chart audits.

Interview with the Interim Administrator on

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D 262	Continued From page 4 10/03/24 on at 2:45pm revealed: -She did not know that Resident #5 did not have a completed and signed care plan. -The HWD was responsible to ensure that each resident had a completed and signed care plan. -The HWD completed a care plan prior to admission and another care plan 14-30 days after admission, and then every six months or if there was a change in condition. -Typically, a nurse completed the care plan. -Chart audits were performed by the HWD and HWC and she was not sure when the last audit was performed. -Chart audits were performed by the Area Nurse Manager (ANM) quarterly and she was not sure when the last audit was completed. -The facility used a compliance tracker to keep up with resident's documents due dates. -She was ultimately responsible to ensure the care plans were competed on time. -She expected each resident to have a current care plan.	D 262		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan.	D 263		

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D 263	Continued From page 5 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents had an accurate care plan signed by their primary care (PCP) within 15 days of the resident being assessed (#5). The findings are: Review of Resident #5's FL-2 dated 09/09/23 revealed diagnoses included atrial fibrillation, transient ischemic attacks, urinary incontinence, vertigo, essential tremor, pacemaker, anxiety, and recurrent urinary tract infections. Review of Resident #5's Resident Register revealed she was admitted on 09/13/24. Review of Resident #5's record revealed that Resident #5 had a completed care plan dated 03/20/24 that was not signed by the primary care provider (PCP). Interview with the Health and Wellness Coordinator (HWC) on 10/03/24 at 11:10am revealed: -She started work at the facility in May 2024. -The Health and Wellness Director (HWD) was responsible for completing care plans. -She had not completed a care plan. -She had not been trained to complete care plans. -She did not know how the facility kept up with what resident was due to have their care plan completed. Interview with the HWD on 10/03/24 at 10:45am revealed: -She started work at the facility in May 2024. -She was responsible for completing care plans.	D 263		

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D 263	Continued From page 6 -She did not know why Resident #5 did not have a completed and signed care plan in her chart. -She used the compliance tracker on their computer to tract when a care plan was due. -She ran a report weekly from the compliance tracker to see what residents needed their care plan updated. -The compliance tracker did not show that there were any care plans due to be updated. -She had not performed any chart audits. Interview with the Interim Administrator on 10/03/24 on 10/03/24 at 2:45pm revealed: -She did not know that Resident #5 did not have a completed and signed care plan. -The HWD was responsible to ensure that each resident had a completed and signed care plan. -The HWD completes a care plan prior to admission and another care plan 14-30 days after admission, and then every six months or if there was a change in condition. -Typically, a nurse completed the care plan. -Chart audits were performed by the HWD and HWC but she was not sure when the last audit was performed. -Chart audits were performed by the Area Nurse Manager (ANM) quarterly and she was not sure when the last audit was completed. -The facility used a compliance tracker to keep up with resident's documents due dates. -She was ultimately responsible to ensure the care plans were competed on time. -She expected each resident to have a current care plan. Attempted telephone interview with Resident #5's primary care provider on 10/03/24 at 2:30pm was unsuccessful.	D 263		

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D 358	Continued From page 7	D 358		
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 and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B violation is abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#1) pertaining to a medication used to treat constipation. The findings are: Review of the facility's medication administration policy dated 05/2011 and revised 12/2020 revealed: -The five rights of medication administration should be observed, 1. the right patient, 2. the right drug, 3. the right dose, 4. the right route, 5. and the right time. -A physician's order should be obtained for medications and medication administration. Review of Resident#1's current FL2 dated 04/18/24 revealed diagnoses included dementia, cerebral infarction, hypertension, atrial flutter and	D 358		

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generalized weakness.

Review of Resident #1's Resident Register revealed she was admitted to the facility on 04/10/23.

Review of Resident #1's signed physicians order sheet dated 04/18/24 revealed an order for Senna Oral Tablet (Senna is a stimulant laxative used to treat constipation), take 1 at bedtime for regular bowel movements.

Observation of Resident #1's medications on hand in the Special Care Unit (SCU) on 10/02/24 at 2:43pm revealed:
-There was no Senna on the medication cart for Resident #1.
-There was bottle of docusate (docusate is a stool softener used to treat constipation) sodium 100mg capsules, with no prescription label.
-Resident #1's name was handwritten on the bottle of docusate sodium 100mg capsules.

Interview with the SCU medication aide (MA) on 10/02/24 at 2:43pm revealed:
-She thought Resident #1's Senna had been discontinued and the docusate was ordered in place of the Senna.
-Resident #1's family provided the docusate sodium for Resident #1.

Telephone interview with a representative at the facility's contracted pharmacy on 10/02/24 at 4:04pm revealed:
-There was no order on file for Senna tablets for Resident #1.
-There was no order for docusate sodium 100mg on file for Resident #1.

An order for docusate sodium 100mg capsules

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was requested from the facility on 10/02/24 at 4:29pm and not provided.

A discontinue order for Senna tablets was requested from the facility on 10/02/24 at 4:29pm and not provided.

Observation of Resident #1's medications on hand on 10/03/24 at 9:25am revealed:
-There was no Senna on the medication cart for Resident #1.
-There was bottle of docusate sodium 100mg capsules, with no prescription label.
-Resident #1's name was handwritten on the bottle of docusate sodium 100mg capsules.
-There was a bottle of docusate sodium 50mg/sennosides (sennosides is the generic name for Senna) 8.6mg tablets, with no prescription label.
-Resident #1's name was handwritten on the bottle of docusate sodium/sennosides tablets.

Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Senna oral tablets, take one tablet at bedtime for regular bowel movements, scheduled for administration at 9:00pm.
-Senna was documented as administered at 9:00pm on 09/01/24 through 09/30/24.

Review of Resident #1's October 2024 eMAR revealed:
-There was an entry for Senna oral tablets, take one tablet at bedtime for regular bowel movements, scheduled for administration at 9:00pm.
-Senna was documented as administered at 9:00pm on 10/01/24 and 10/02/24.

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D 358	Continued From page 10 Second interview with the SCU MA on 10/03/24 at 9:33am revealed: -Resident #1's prescription medications were provided by her family from an outside mail order pharmacy. -If Resident #1 needed a short-term medication, it was provided by a local retail pharmacy. -The over-the-counter docusate and docusate/sennosides for Resident #1 were provided by her family. -Outside medications brought in for the residents were given to either the MAs, the Health Wellness Director (HWD), or the Health and Wellness Coordinator (HWC). -Outside medications for the residents were to be compared to the eMAR for accuracy. -If a medication did not match the eMAR, she either contacted the resident's family member, the HWC and /or HWD, or the resident's PCP. -The facility's contracted pharmacy provider performed medication cart audits periodically. -She thought the HWD or the HWC performed monthly cart audits. -She was not sure why docusate sodium capsules and docusate/sennosides tablets were on the medication cart for Resident #1 instead of Senna. -She did not realize there was no Senna on the medication cart for Resident #1 because she worked the day shift, and the Senna was ordered to be administered at bedtime. Interview with the Special Care Unit Coordinator (SCUC) on 10/03/24 at 10:37am revealed: -The MAs compared the residents' medication labels to the residents' eMAR prior to the medications being administered. -If a resident's family member brought in outside medications, the medications were given to either	D 358		

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the MA, the HWC or the HWD.
-All outside medications brought in for a resident were compared the resident's eMAR.
-If an outside medication brought in for a resident did not match the eMAR, the MA notified the HWC and/or the HWD, contacted the resident's family or contacted the resident's PCP for clarification or an order change.
-The MAs in the SCU were supervised by the HWC and the HWD.

Telephone interview with Resident #1's mail order pharmacy on 10/03/24 at 9:44am revealed:
-There was no order on file for Senna tablets.
-There was no order on file for docusate sodium 100mg capsules.
-There was no order on file for docusate sodium 50mg/sennosides 8.6mg tablets.

Telephone interview with Resident #1's local retail pharmacy on 10/03/24 at 9:52am revealed:
-There was no order on file for Senna tablets.
-There was no order on file for docusate sodium 100mg capsules.
-There was no order on file for docusate sodium 50mg/sennosides 8.6mg tablets.

Telephone interview with Resident #1's responsible party (RP) on 10/03/24 at 9:55am revealed:
-The majority of Resident #1's medications were dispensed from a mail order pharmacy.
-Resident #1's over the counter medications were provided by her family.
-Resident #1's primary care provider (PCP) advised her what over the counter medications to purchase for Resident #1.
-There had been no problems with Resident #1's medications that she was aware of.
-When she took Resident #1's medications to the

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facility, she gave them to the MA.

Telephone interview with the medical assistant at Resident #1's PCP's office on 10/03/24 at 11:27am revealed:
-Senna oral tablets were originally ordered for Resident #1 on 04/14/23 to take one daily at bedtime.
-The order for Senna tablets was re-certified for Resident #1 on 06/16/24, to take one daily at bedtime.
-Docusate sodium 100mg capsules had not been ordered for Resident #1.
-Docusate sodium 50mg/sennosides 8.6mg tablets had not been ordered for Resident #1.

Interview with HWC, who was a Licensed Practical Nurse (LPN), on 10/03/24 at 11:14am revealed:
-She started at the facility in May 2024.
-She supervised the MAs in the SCU.
-The MAs were to administer medications per the 7 Rights of Medication Administration.
-If a family member provided outside medications for a resident, the MAs were to always check the medication against the eMAR.
-If a resident's medication did not match the eMAR entry, the MA should notify her, the HWD or contact the resident's PCP for clarification or for a new order.
-The MAs were to expected to always compare a resident's medication to the resident's eMAR prior to administering.
-She, the HWD or the MAs could perform medication cart audits.
-Medication cart audits involved checking for expired or discontinued medications, making sure medications were on the cart and comparing the medications to the eMAR.
-She thought the night shift MA performed

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medication cart audits every one or two weeks but was not certain how often medication cart audits were to be performed and was not sure when the SCU medication cart was last audited.
-She had not performed a medication cart audit in the SCU.
-She did not know why Resident #1 did not have Senna tablets available for administration.

Interview with the HWD, who was a Registered Nurse (RN) on 10/03/24 at 11:32am revealed:
-She had started at the facility in May of 2024.
-The MAs were to always observe the 7 Rights of Medication Administration.
-When medications were administered, the MAs were to compare the residents' medication label to the eMAR when the medication was pulled from the drawer, when the medication was popped or poured and when the medication was returned to the drawer.
-Resident #1's outside medications should have been compared to her eMAR to make sure it was the correct medication and the correct dosage.
-She, the HWC and the MAs were responsible for medication cart audits.
-A medication cart audit consisted of looking for expired or discontinued medications, comparing the medications to the eMAR and making sure the residents' medications were available.
-She was not sure when the SCU medication cart was last audited.
-She expected the residents to receive the correct medications as ordered.

Interview with the Interim Administrator on 10/03/24 at 3:21pm revealed:
-Medications were to be administered to the residents by observing the 7 Rights of Medication Administration.
-The MAs were expected to always compare the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL016006	A. BUILDING: _____ B. WING _____	R 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MOREHEAD CITY	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 358	Continued From page 14 medication label to the eMAR entry for each resident. -Outside medications provided for the residents should always be compared to the eMAR to insure it was the correct medication and the correct dosage. -If the outside medication brought in for the resident was not correct, the resident's family member should have been notified, or the HWD/HWC should have been notified, or the resident's PCP should have been contacted. -The MAs were responsible for medication cart audits with the oversight of the HWC then the HWD. -A medication cart audit consisted of looking for expired or discontinued medications and making sure the correct medications were on the cart and available to the resident by comparing the medications with the eMAR. -She expected the correct medications to be available to the residents for administration.	D 358		