Division of Health Service Regulation

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 _____	03/12/2026

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

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on March 10, 2026-March 12, 2026.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 1 of 3 sampled staff who administered medications to residents passed the medication aide (MA) test for adult care homes within 60 days of their completed medication administration skills validation form (Staff B). Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on 09/26/11. -Staff B completed a state approved nursing assistant course on 06/10/11. -Staff B's medication administration skills validation form was dated 02/20/12. -There were no results for the medication aide test for adult care homes.	D 125	Community has implemented an internal audit of all Med Techs to ensure each have taken and passed the Med Aid for Adult Care Homes. Community will continue with all new hires and any current staff that is trained for Med Tech to not be allowed to pass Meds unless they have taken and passed the Med Aide for Adult Care Homes. We will put in place that no Med Tech be allowed to work as a Med Tech until we have put them through our Brookdale Med Tech class and taken and passed the NC State Issued Med Tech for Adult Care Homes Exam.The ED, BOC and HWD will continue to monitor all current and future new hires to ensure this does not happen again.This will be monitored after each new hire and after each internal promotion of a care giver to med Tech. This is implemented as of 3/16/26 and completed and will continue to be ongoing as needed.	3/16/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bobby E. Dillard II | TITLE: Executive Director | (X6) DATE: 4/15/26

Received and Acknowledged on 2026-04-17 by NURSE CONSULTANT Linda B. Nielsen

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D 125	Continued From page 1 -Staff B had taken and passed the medication aide exam for skilled nursing homes on 10/22/11. Review of the North Carolina Adult Care Medication Aide Testing website on 03/12/26 at 11:36am revealed there were no results located for Staff B having taken and passed the exam. Observation of the morning medication pass on 03/11/26 at 7:43am revealed Staff B was observed administering medications to residents. Interview with Staff B on 03/12/26 at 10:47am revealed: -She had worked at the facility since 2011. -She had not completed the 5-, 10-, or 15-hour medication aide course since she had completed the medication aide course at the local community college. -She had not taken the North Carolina Adult Care Medication Aide Test since she had taken and passed the medication aide exam for skilled nursing homes. Interview with the Business Officer Manager (BOM) on 03/12/26 at 10:45am revealed: -She became the BOM in 2006. -She was responsible for ensuring the staff qualifications were met. -This was the first time Staff B's personnel record had been reviewed during a state survey. -She was informed Staff B did not have to complete the 5-, 10-, or 15-hour medication aide course since Staff B had completed the medication aide course at the local community college. -She was not aware that Staff B had to take the North Carolina Adult Care Medication Aide Test since Staff B had taken and passed the medication aide exam for skilled nursing homes.	D 125		

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D 125	Continued From page 2 Interview with the Executive Director on 03/12/26 at 11:55am revealed: -The BOM and Staff B were employed by the facility prior to his starting date. -The BOM was responsible for ensuring the staff qualifications were met. -He was aware that MAs were required to take their MA test within 60 days of their medication administration skills validation. -He was not aware that Staff B had not taken the MA test for adult care homes.	D 125		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents (#1) who had an order for thromboembolism-deterrent (TED) hose. The findings are: Review of Resident #1's current FL2 dated 12/22/25 revealed:	D 276	Educated Med Techs, to document order changes in the EMar vs the TAR. Monthly review withall Med Techs to ensure carryover. Will continue toutilize the New Order Tracking that is reviewed daily with all new orders by the RCC then the HWD. RCC and HWD will monitor as necessary with New Orders and weekly audits. 3/16/26.	3/16/26

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D 276	Continued From page 3	D 276		

-Diagnoses included essential hypertension, hypothyroidism, anxiety, and type 2 diabetes.
-There was no information on orientation.

Review of Resident #1's Resident Register revealed she was admitted to the facility on 08/28/21.

Review of Resident #1's signed physician's order sheet dated 01/21/26 revealed an order for thromboembolism-deterrent (TED hose to be applied every morning to bilateral lower extremities and removed at bedtime for edema.

Review of Resident #1's licensed health professional support (LHPS) quarterly review revealed a personal care task of applying and removing TED hose.

Review of Resident #1's January 2026 electronic medication administration record (eMAR) revealed there was no entry for TED hose.

Review of Resident #1's February 2026 eMAR revealed there was no entry for TED hose.

Review of Resident #1's March 2026 eMAR revealed there was no entry for TED hose.

Observation of Resident #1 on 03/11/26 at 11:40am revealed:
-Resident #1 was lying in her room on her bed.
-Resident #1 was not wearing her TED hose.

Interview with Resident #1 on 03/11/26 at 11:40am revealed:
-Staff did apply TED hose to her sometimes.
-She did not know if staff applied her TED hose that morning.
-She was not aware of the last time she wore her

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D 276	Continued From page 4 TED hose. Interview with a medication aide (MA) on 03/11/26 at 1:40pm revealed: -Resident #1 used to wear TED hose daily. -Resident #1's TED hose had been discontinued. -She was not sure of when Resident #1's TED hose were discontinued. -Resident #1 allowed the MAs to apply and remove her TED hose with no problems. Interview with the Resident Care Cordinator (RCC) on 03/12/26 at 8:35am revealed: -Resident #1 had not worn her TED hose since 01/09/26. -An MA entered Resident #1's TED hose in the system under advanced directives, and that is why it did not appear on the eMAR. -Resident #1's TED hose should have been added to the eMAR by the facility. -The primary care provider (PCP) discontinued Resident #1's TED hose from 01/09/26 through 03/09/26 due to a sore on Resident #1's left ankle. -There should have been an entry for TED hose on Resident #1's eMAR. -Resident #1 should have had her TED hose applied on 03/11/26. -The MAs were responsible for ensuring orders were placed on the eMAR. -The RCC and health and wellness director (HWD) were responsible for checking that the MAs were placing orders on the eMARs. -She was concerned that there was not a process in place for adding orders back to the eMARs that have been discontinued for a specific period of time. Interview with a second MA on 03/12/26 at 9:35am revealed:	D 276		

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D 276	Continued From page 5 -When there were orders for TED hose the MAs were responsible for measuring the resident for a proper size then calling the pharmacy to order the TED hose. -The MAs were responsible for adding TED hose to the eMAR. -If there was a discontinue order the MAs were responsible for removing the TED hose from the eMAR. -Resident #1's TED hose should have been entered back on the eMAR on 03/10/26. -The RCC and MAs were responsible for ensuring the TED hose were added back to the eMAR. Interview with the RCC on 03/12/26 at 8:35am revealed: -Resident #1 had not worn her TED hose since 01/09/26. -An MA entered Resident #1's TED hose in the system under advanced directives, that is why it did not appear on the eMAR. -Resident #1's TED hose should have been added to the eMAR by the facility. -The PCP discontinued Resident #1's TED hose from 01/09/26 through 03/09/26 due to a sore on Resident #1's left ankle. -There should have been an entry for TED hose on Resident #1's eMAR. -Resident #1 should have had her TED hose applied on 03/11/26. -The MAs were responsible for ensuring orders were placed on the eMAR. -The RCC and health and wellness director (HWD) were responsible for checking that the MAs were placing orders on the eMARs. -She was concerned that there was not a process in place for adding orders back to the eMARs that have been discontinued for a specific period of time.	D 276		

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D 276	Continued From page 6 Interview with the Administrator on 03/12/26 at 9:45am revealed: -It was the responsibility of the MAs and the RCC to make sure all treatments and orders were carried out. -It was the responsibility of the MAs and the RCC to make sure all orders were put on the eMAR. -The HWD and RCC were responsible for ensuring the MAs placed orders on the eMAR properly. -He was concerned that Resident #1's order was not followed as prescribed. Interview with Resident#1's primary care provider (PCP) on 03/12/26 at 10:00am revealed: -Resident #1 was ordered TED hose for edema. -Resident #1's TED hose were discontinued from 01/09/26-03/09/26 due to a sore on her ankle. -Resident #1 should have had her TED hose applied on 03/11/26. -Resident #1 could be uncomfortable if her TED hose were not applied and removed daily. -She was not concerned because the nurse saw the Resident #1 weekly and would have realizided that her TED hose needed to be applied.	D 276		
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.	D 358		

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D 358	Continued From page 7 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#6) observed during the medication pass where the medications were crushed without an order to crush the resident medications and included an extended-release medication which was crushed. Review of the facility's Medication and Treatment - General Guidelines for Medication Administration dated 09/2025 revealed: -Crushing tablets or opening capsules should be avoided. -Follow the pharmacy labeling for safe medication handling practices. -Crushed medications required a physician/Health Care Provider (HCP) order. -Sustained-release and enteric coated medications should not be crushed. -Each Medication Administration Record (MAR) book, if utilized, should have a list of medications not to be crushed. -Residents were to be told when medications were crushed. -A physician/healthcare provider order was required before crushing of a medication administered to a resident. -MAs are encouraged to check with a pharmacist or access the "Do Not Crush" list provided by the pharmacy for further information on the specific medication. -All oral solids that are manufactured in such a way that the action of the medication would be altered by the crushing of the medication, or such crushing would make the product unsafe to be given in an oral route, will not be crushed prior to administration to the resident. -Reasons Not to Crush: although most solid	D 358	Community educated all Med Techs on appropriate medication administration orders and to review all cards of meds that are administered for any residents that have orders to crush meds wether stated on the card if not to crush. Community educated all med techs on proper reading of medication cards with following pharmacy instructions. Educated all med techs with ensuring to read and understand all meds that are listed as "do not crush." HWD to monitor all med orders to crush and will do monthly audits with all Med Techs of passing meds while visably monitoring a complete med pass. This is implemented as of 3/16/26.	3/16/26

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D 358	Continued From page 8	D 358		

dosage forms of oral medication may be crushed for ease of administration without adversely affecting medication therapy or resident comfort, some tablets and capsules may not be crushed.
-Enteric Coated (EC) tablets dissolve in the intestine and protect medications such as enzymes from destruction by stomach acid or protect the stomach from irritating medications.
-Sustained Release (SR) dosage forms contain smaller particles or sections that are released for up to 12 hours.
-These forms include the familiar "bead" containing capsules (e.g., spansules), granules within tablets, slow-release tablet cores, tablets composed of wax matrix, and plastic tablets with many small passages.
-Some SR tablets that are not scored should not be broken.
-Prior to crushing any medication, the MA will refer to the medication label for any cautionary statements regarding "Do Not Crush" status.
-Every attempt needs to be made to refrain from crushing medications that should not be crushed.
-The MA should discuss other methods of administering the medication with the designated pharmacy and the physician prior to requesting an order to crush that particular medication.
-If a physician/healthcare provider wishes a medication that carries a cautionary statement of "Do Not Crush" to be crushed, a specific order is needed to authorize the crushing of that medication.

The medication error rate was 4% as evidenced by 1 error out of 25 opportunities during the 7:00am/8:00am medication pass on 03/11/26.

Review of Resident #6's current FL-2 dated 10/07/25 revealed:
-Diagnoses included Alzheimer's disease,

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D 358	Continued From page 9 Generalized anxiety disorder, Congenital insufficiency of aortic valve, hyperlipidemia, hypothyroidism, rheumatoid arthritis, overactive bladder, and personal history of malignant neoplasm of the ovaries. -There was an order for acetaminophen extra strength 500mg (used to treat minor aches and pains, including headache, backache, minor pain of arthritis, toothache, muscular aches, premenstrual and menstrual cramps) one tablet twice a day. -There was an order for hydroxychloroquine 200 mg (used to treat conditions such as rheumatoid arthritis) one tablet every day. -There was an order for levothyroxine 50 mcg (used to treat an underactive thyroid - a condition where the thyroid gland does not produce enough thyroid hormone) one every day. -There was an order for Myrbetriq extended release 50 mg (used to treat an overactive bladder with symptoms of frequent or urgent urination and urinary incontinence) one every day. -There was an order for Sertraline hydrochloride 50 mg (used to treat depression, anxiety disorders, obsessive-compulsive disorder, post-traumatic stress disorder, social anxiety disorder, and premenstrual dysphoric disorder) one every day. -There was an order for Vitamin D3 2000 IU (used to treat help regulate calcium and phosphorus, which is essential for building and maintaining strong bones and teeth and helps prevent deficiencies that can lead to osteoporosis or fractures) one every day. Review of Resident #6's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for acetaminophen extra	D 358		

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D 358	Continued From page 10	D 358		

strength 500mg one tablet twice a day and it was documented as administered on 03/11/26 at 7:00am.
-There was an entry for hydroxychloroquine 200 mg one tablet every day and it was documented as administered on 03/11/26 at 7:00am.
-There was an entry for levothyroxine 50 mcg one every day and it was documented as administered on 03/11/26 at 7:00am.
-There was an entry for Myrbetriq extended release 50 mg one every day and it was documented as administered on 03/11/26 at 7:00am.
-There was an entry for Sertraline hydrochloride 50 mg (one every day. and it was documented as administered on 03/11/26 at 7:00am.
-There was an entry for Vitamin D3 2000 IU one every day and it was documented as administered on 03/11/26 at 7:00am.
-There was no entry for medications to be crushed.

Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 03/11/26 from 7:25am - 7:28am revealed:
-At 7:25am, the MA opened a drawer of the medication cart, retrieved, and prepared 6 medications for Resident #6.
-These medications included Tylenol Extra Strength 500mg, hydroxychloroquine 200 mg, levothyroxine 50 mcg, vitamin D3 2000IU, sertraline HCL 50 mg, and Myrbetriq ER 50mg.
-The label on the Myrbetriq ER 50mg included the order of "DO NOT CRUSH".
-The MA took the medication cup with the 6 prepared medications and placed them into a plastic sleeve and used the pill crusher and crushed all the medications in the sleeve.
-The MA placed applesauce into a medication

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D 358	Continued From page 11	D 358		

cup and poured the crushed medications from the plastic sleeve onto the applesauce and mixed the crushed medications into the applesauce.
-The MA administered the applesauce with the medications mixed in to Resident #6.

Review of Resident #6's medical record revealed there was no order to crush medications.

Interview with the MA on 03/11/26 at 1:35pm revealed:
-She had been told that Resident #6 would not take her medications whole, so she crushed them to make sure Resident #6 received her medications.
-She was not aware that Resident #6 did not have an order to crush medications.
-There was a book on the medication cart that had the medications that could not be crushed.
-She had overlooked the "DO NOT CRUSH" on the medication card for Resident #6's Myrbetriq ER 50mg tablet.

Interview with the Resident Care Coordinator (RCC) on 03/12/26 at 8:55am revealed:
-She was concerned about the MAs crushing medications without an order but especially crushing an extended-release medication.
-The MA should not crush any medication without an order.
-The MA should have checked the labels completely.
-The MA should have contacted the primary care provider (PCP) when Resident #6 was not able to take her medications whole and received an order to crush her medications.

Interview with the Health and Wellness Director (HWD) on 03/11/26 at 12:00pm revealed:
-The MA should not crush any medication without

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D 358	Continued From page 12	D 358		

an order and never crush anything that was an extended release.
-The MA should have done her 3 checks, and she would have seen the "DO NOT CRUSH" on the medication card.
-The medication carts have a list of medications that could not be crushed.
-The MA could have let the HWD know that Resident #6 was not able to take her medications whole and the HWD could have reached out to the PCP for an order to crush her medications.

Interview with the Executive Director on 03/12/26 at 9:15am revealed:
-The MAs received training on how and when to crush medications.
-He expected the MAs to follow proper policies and procedures and never crush medications without an order.

Telephone interview with the facility's contracted pharmacist on 03/11/26 at 11:26am revealed:
-Any specific questions would need to go through the pharmacy's quality assurance department; she could only answer general questions.
-Medications should not be crushed without an order from the PCP.
-She deferred to the manufacturer's guidelines regarding crushing of extended-release medication such as Myrbetriq.

Interview with Resident #6's primary care provider on 03/11/26 at 9:50am revealed:
-The PCP should have been contacted to receive a crush order for her medications or orders for an alternate form of her medications.
-MAs should never crush medications without an order to do so.
-Extended-release medications slowly release a small amount of medication over a period of time;

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 _____	03/12/2026

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 358	Continued From page 13 crushing this type of medication defeats the purpose of it be extended release and can put the crushed medication into the resident's system all at once.	D 358		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered in accordance with infection control measures by a medication aide, who picked up the medication which had fallen onto the floor with her bare hand and placed it into the medication cup for the resident to take. The findings are: Review of the facility's Medication and Treatment - General Guidelines for Medication Administration dated 09/2025 revealed: -Trained and/or licensed associates may administer or assist the resident with medication management or medication administration and treatments per physician/healthcare provider (HCP) order and as per state regulation. -Follow the pharmacy labeling for safe medication handling practices.	D 371	Community has educated all staff, specifically med techs with infection control with passing meds. Wearing gloves where applicable with cutting meds and any instances where they would need to touch the meds. All med techs have went through an e-learning throughout month of March and live training for infection control on 4/15/26. Monitoring to be done by HWD monthly for all med tech med pass audits for compliance to infection control. Quarterly training for infection control and proper PPE compliance.	4/15/26

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D 371	Continued From page 14	D 371		

-Gloves should also be worn when cutting tablets in half or touching them for other reasons.
-Medication or treatment directions on the physician/HCP order and pharmacy label should correlate with the medication or treatment directions on the MAR/MOR/eMAR or TAR.

Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 03/11/26 from 7:43am - 7:59am revealed:
-There was a bottle of hand sanitizer on the medication cart.
-At 7:43am, the MA opened a drawer of the medication cart, retrieved, and prepared 4 medications for a resident.
-The MA took the medication cup with the 4 prepared medications over to the resident who was seated in a chair.
-The MA handed the cup to the resident.
-The resident dropped the medication cup and 3 of the 4 medications fell in her lap and 1 small white caplet fell on the floor.
-The MA, with her bare fingers, picked up the 1 white caplet from the floor and placed it back into the medication cup.
-The resident picked up the remaining medications from her lap and put them back into the medication cup.
-Before the surveyor could stop the resident, she had placed the 4 medications from the medication cup into her mouth and swallowed them with water.
-The MA continued with the morning medication pass.

Interview with the MA on 03/11/26 at 1:35pm revealed:
-She should have worn gloves before touching any medication.

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D 371	Continued From page 15 -She was concerned about the resident running out of medications if she had to dispose of the medications that were contaminated after the pill fell on the floor since the facility was on a cycle-fill (Cycle fill medications - a pharmacy service that synchronizes, packages, and refills a patient's routine, long-term prescriptions on a consistent, scheduled basis (e.g., every 7, 14, or 30 days) which reduced medication waste, eliminated the need to call in refills, and ensured residents in long-term care facilities never run out). -She panicked when the resident dropped the medications and was nervous being watched. -She had infection control training and knew what she did was a potential risk for spreading infections. -She should have disposed of the medication which had fallen on the floor following the facility's policy. -She should have gotten another caplet from the bubble pack to administer to the resident. -Then she should have called the pharmacy to inform them of the medication disposal so the pharmacy could send a replacement.	D 371		