STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 a follow-up survey on 01/26/22 to 01/27/22.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION. The Type A2 Violation was abated. Non-compliance continues. Based on interviews and record reviews the facility failed to notify the primary care provider of 2 of 3 sampled residents. (#4, #5) related to missed doses of an antidepressant (#4) and failed to ensure a follow-up appointment was completed for a resident discharged from the emergency room with his primary care provider (#5). The findings are: 1.Review of Resident #4's current FL-2 dated 03/31/21 revealed: -Diagnoses included fracture of left femur, muscle weakness, major depressive disorder, atrial fibrillation, chronic kidney disease stage III, history of transient ischemic attack, osteoarthritis, and hypertension. -There was an order for Zoloft 50mg daily. (Zoloft is a medication used to treat depression.) Review of Resident #4's electronic Medication Administration Record (eMAR) revealed:	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 1 -There was an entry for Zoloft 50mg scheduled to be administered at 1:00pm daily. -There was documentation of "16" which indicated "pharmacy action required" on 01/25/22, 01/26/22, and 01/27/22. Review of Resident #4's record revealed that there was no documentation that her physician had been notified that she was out of her Zoloft and had missed three doses. Interview with Resident #4 on 01/27/22 at 10:20am revealed: -She had been without her Zoloft for a few days. -She did not feel depressed but did not sleep well last night. -Her family member had taught the Resident Care Coordinator (RCC) how to order her medications on the resident's computer. -The RCC was out sick last week so her Zoloft did not get reordered. Interview with the medication aide (MA) on 01/26/22 at 12:22pm revealed: -Resident #4's family member ordered her medications from her private pharmacy. -The resident's family member was aware that the resident was out of Zoloft and staff was waiting for him to order it. Interview with the RCC on 12/27/22 at 10:53am revealed: -He received notification from MAs when a resident was running out of medications. -Physicians were not notified if residents ran out of medications and miss doses. Telephone interview with Resident #4's family member on 01/27/22 at 2:20pm revealed: -Resident #4 was on Zoloft for the treatment of	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 2	{D 273}		

depression.
-Her depression had become worse during the COVID-19 pandemic and following a fall with injury when she had to be relocated to a skilled nursing facility for rehabilitation.
-He received a call from a MA at the facility on 01/21/22 stating that Resident #4 only had 3 doses of her Zoloft remaining.
-He expected the facility staff to reorder the medications needed prior to them running out.
-He was a Medical Physician and was concerned that Zoloft was not a medication that should be missed or stopped abruptly and her physician should have been notified.

Interview with the Administrator on 01/27/22 at 11:00am revealed:
-She did not know Resident #4's Zoloft did not get reordered when the RCC was off last week.
-Resident #4's physician should be contacted right away if the facility was unable to get a resident's medication.
-The MAs reported to the RCC or Health and Wellness Director (HWD) if the residents were out of medication.
-If the RCC or HWD was notified there should be documentation that the resident was out of medication.

Attempted telephone interview with Resident #4's Primary Care Provider on 01/27/22 at 9:36am and was unsuccessful.

2. Review of Resident #5's current FL-2 dated 11/15/21 revealed:
-Diagnoses include Alzheimer's, glaucoma, and hypertension.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 3 Review of Resident #5's facility progress notes revealed the resident was admitted to the facility on 11/18/21. Review of Resident #5's facility progress note dated 11/30/21 revealed: -Resident #5 was feeling weak and was lowered to the ground by the staff. -Resident was transported to the emergency room by Emergency Medical Services for evaluation. Review of Resident #5 emergency room discharge instructions dated 11/30/21 revealed: -The resident was seen in the emergency room for hypotension (low blood pressure) and a near syncopal episode. -The resident was discharged back to the facility with instructions to follow up with his primary care provider (PCP) after discharge. -There was no timeframe noted for follow up with his PCP noted. Telephone interview with Resident #5 primary care provider (PCP) office assistant on 01/27/22 at 11:15am revealed: -His last visit to the office was on 11/17/21. -He has not been seen by his PCP since his admission to the facility. Interview with the Resident Care Coordinator (RCC) on 01/27/22 at 9:45am revealed: -When a resident was discharged from the emergency room with orders for a physician follow up visit it was the responsibility of the facility to ensure that was done. -When the resident returned from the hospital, either a medication aide (MA) or himself or the Health and Wellness Director (HWD) would be responsible for calling to schedule Resident #5's	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 4 hospital follow-up appointment the next business day. -He was not sure if Resident #5 has been seen by the facility's contracted PCP since discharge from the emergency room. Interview with the HWD on 01/27/22 at 11:50am revealed: -She was not aware Resident #5 went to the emergency room on 11/30/21 because she was out on medical leave. -Resident #5 should have followed up with his PCP after discharge from the emergency room as directed. -The RCC was responsible for scheduling resident appointments and maintaining the schedule of appointments. -She was not able to see if the resident was seen by the facility's contracted PCP since 11/30/21 because the provider's notes for December 2021 and January 2022 notes were not available. Interview with the Administrator on 01/27/22 at 2:33pm revealed she expected that Resident #5 would have seen his PCP after the emergency room visit. Based observations and interviews, it was determined that Resident #5 was not interviewable. Attempted telephone interview with the facility's contracted PCP on 01/27/22 at 1:52pm was unsuccessful. Attempted telephone interview with Resident #5's family on 01/27/22 at 1:25pm was unsuccessful.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 276}	Continued From page 5	{D 276}		
{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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure implementation of physician's orders for 2 of 5 sampled residents (#1, #5) regarding compression stockings and weekly weights (#1) and a valproic acid level (#5). The findings are: 1. Review of Resident #1's current FL-2 dated 10/05/21 revealed: -Diagnoses included edema. -There was an order for compression stockings to be applied daily in the morning and remove before bedtime. Observation of Resident #1 on 01/26/22 at 8:49am revealed he was not wearing compression stockings. A second observation of Resident #1 on 01/27/22 at 9:32am revealed he was not wearing	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 276}	Continued From page 6 compression stockings. Review of Resident #1's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for compression stockings in the morning and remove per schedule, scheduled to apply at 6:30am and remove at 8:00pm. -Compression stockings were documented as applied on 01/26/22 at 6:30am and documented as removed on 01/26/22 at 8:00pm. -Compression stockings were documented as applied on 01/27/22 at 6:30am. Observation of Resident #1's resident room on 01/27/22 at 9:35am revealed the medication aide (MA) on duty could not locate the compression stockings. Interview with a MA on 01/27/22 at 9:35am revealed: -Third shift was responsible for applying Resident #1's compression stockings and second shift was responsible for removing the compression stockings. -The computer system prompted the reminder to apply compression stockings for third shift and remove compression stockings for second shift. -She was not sure why Resident #1 did not have on compression stockings, but he did not currently have lower extremity edema. Interview with the Resident Care Coordinator (RCC) on 01/27/22 at 9:45am revealed: -He expected Resident #1's compression stockings to be applied as ordered. -He was not aware that Resident #1 did not have his compression stockings applied on 01/26/22 or 01/27/22. -Third shift MAs were responsible for applying	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 276}	Continued From page 7 Resident #1's compression stockings and second shift MAs were responsible for removing the compression stockings. Interview with the Administrator on 01/27/22 2:33pm revealed she was not aware that Resident #1 did not have his compression stockings applied and she expected the MAs to carry out physician orders as directed including orders for compression stockings. Interview with Resident #1's primary care provider (PCP) on 01/27/22 at 9:57am revealed she expected physician orders to be accurately implemented on Resident #1 including his compression stockings. Based observations and interviews, it was determined that Resident #1 was not interviewable. 2. Review of Resident #'s 1 current FL-2 dated 10/05/21 revealed: -Diagnoses included edema. -There was an order for weekly weights. Review of Resident #1's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for weekly weights every Wednesday, scheduled for day shift. -There was a weight documented for 11/03/21 and 11/10/21. -There was no weight documented for 11/17/21 and 11/24/21. Review of Resident #1's December 2021 eMAR revealed: -There was an entry for weekly weights every Wednesday, scheduled for day shift.	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 276}	Continued From page 8 -There was a weight documented for 12/01/21 and 12/15/21. -There was no weight documented for 12/08/21. Review of a physician order dated December 22, 2021 revealed the order for weekly weights for Resident #1 were discontinued. Interview with a medication aide (MA) on 01/27/22 at 9:35am revealed: -It was the MA's responsibility to ensure weights were completed and documented. -The computer system prompted the MA to get resident weights when ordered. Interview with the Health and Wellness Director (HWD) on 01/27/22 at 11:50am revealed: -Resident #1 was sometimes non-compliant with staff and they were not able to weight him but she expected staff to document if that was the case. -She contacted his primary care provider (PCP) on 12/22/21 to get them discontinued. -She completed a weight audit 12/22/21 and noticed that he was not being weighed weekly. Interview with the Administrator on 01/27/22 2:33pm revealed she was not aware that Resident #1 did not have weekly weights completed and she expected the MAs to carry out physician orders as directed including weekly weights. Based observations and interviews, it was determined that Resident #1 was not interviewable. 3. Review of Resident #5's current FL-2 dated 11/15/21 revealed: -Diagnoses include Alzheimer's disease.	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 276}	Continued From page 9 Review of Resident #5's facility progress notes revealed the resident was admitted to the facility on 11/18/21. Review of Resident #5's mental health providers visit note dated 12/20/21 revealed there was an order for a valproic acid level to be drawn in 7 days because of a dose change in medication. Review of Resident #5's record revealed there was no valproic acid level drawn on 12/27/21. Interview with the Health and Wellness Director (HWD) on 01/27/22 at 1:53pm revealed the mental health provider contracted with an outside agency for laboratory work and the facility was not aware that the valproic acid level ordered for 12/27/21 was not completed. Interview with Resident #5's mental health provider on 01/27/22 at 12:39pm revealed: -The provider contracted with a laboratory to draw orders and have them directly sent to the provider. -She was monitoring Resident #5's valproic acid level due to a dose change and the resident's family was worried about potential toxicity. -She was not concerned about Resident #5's valproic acid level not being completed a week after the dose change because it was low when drawn. Interview with the Administrator on 01/27/22 at 2:33pm revealed she expected the facility to ensure all orders were completed, including Resident #5's valproic acid level. Based observations and interviews, it was determined that Resident #5 was not interviewable.	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 276}	Continued From page 10 Attempted telephone interview with Resident #5's family on 01/27/22 at 1:25pm was unsuccessful.	{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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered to 2 of 3 sampled residents (Resident #1 and #4) with an order for an antidepressant (#4) and pain medication (#1). The findings are: 1. Review of Resident #4's current FL-2 dated 03/31/21 revealed: -Diagnoses included fracture of left femur, muscle weakness, major depressive disorder, atrial fibrillation, chronic kidney disease stage III, history of transient ischemic attack, osteoarthritis, and hypertension. -There was an order for Zoloft 50mg daily. (Zoloft is a medication used to treat depression.) Review of Resident #4's electronic Medication Administration Record (eMAR) revealed: -There was an entry for Zoloft 50mg scheduled to	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 11	{D 358}		

be administered at 1:00pm daily.
-There was documentation of "16" which indicated "pharmacy action required" on 01/25/22, 01/26/22, and 01/27/22.

Observation of Resident #4's medications on hand on 01/26/22 at 12:22pm revealed that she did not have any Zoloft available for administration.

Interview with Resident #4 on 01/27/22 at 10:20am revealed:
-She had been without her Zoloft for a few days.
-Her family member would be told by the facility staff to reorder her medicine.
-Her family taught the Resident Care Coordinator (RCC) how to order her medications on the resident's computer.
-The RCC was out sick last week so her Zoloft did not get reordered.

Interview with the medication aide (MA) on 01/26/22 at 12:22pm revealed:
-Resident #4's family member ordered her medications from her private pharmacy.
-The resident's family member was aware that the resident was out of Zoloft and staff was waiting for him to order it.
-Resident #4's private pharmacy prescriptions could only be reordered on the resident's personal computer.
-The resident's family member ordered through the resident's private pharmacy instead of the facility contracted pharmacy because the family member said it was less expensive.
-The resident let the facility order some of her medication through the facility's contracted pharmacy.

Interview with the Resident Care Coordinator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 (RCC) on 01/27/22 at 10:53am revealed: -He received notification from MAs when a resident was running out of medications. -He received notification when the resident had around 14 pills left. -He ordered Resident #4's medications from resident's private pharmacy on the resident's personal computer. -If he was absent he could talk a MA through how to reorder medication on the resident's computer. -If the resident ran out of medication the facility was able to use the contracted pharmacy to get the medication. -He was out sick last week. -He ordered Resident #4's Zoloft from Resident #4's private pharmacy on 12/24/22 when he returned to work. Telephone interview with a Patient Care Advocate at Resident #4's private pharmacy on 01/27/22 at 9:45am revealed: -A 30 day supply of Zoloft was shipped on 12/21/21. -A 30 day supply of Zoloft was shipped on 01/26/22. -Estimated delivery of Resident #4's Zoloft was 01/31/22. Telephone interview with Resident #4's family member on 01/27/22 at 2:20pm revealed: -Resident #4 used a private pharmacy for her medications because of her insurance. -He had instructed the Resident Care Coordinator (RCC) at the facility how to order the medications and had set up the resident's personal computer with an account with attached credit card and given full access for any medications on the account to be ordered. -He had not instructed anyone else at the facility how to utilize the computer for reordering but	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 would expect another staff such as the Health and Wellness Director to order medications if the RCC was not available. -He received a call from a medication aide (MA) at the facility on 01/21/22 stating that Resident #4 only had 3 doses of her Zoloft remaining. -He expected the facility staff to reorder the medications needed prior to them running out. -He was a Medical Physician and was concerned that Zoloft was not a medication that should be missed or stopped abruptly. Interview with the Administrator on 01/27/22 at 11:00am revealed: -She did not know that Resident #4 got her medications through a private pharmacy. -She did not know the RCC ordered the resident's medications on her computer. -She did not know Resident #4's Zoloft did not get reordered when the RCC was off last week. -Zoloft should have been ordered at least five days before it ran out. -Resident should never run out of medication. -If the resident runs out of medication it should be ordered from the facility's contracted pharmacy until it arrives from her private pharmacy. -The MAs reported to the RCC or Health and Wellness Director (HWD) if the residents were out of medication. -If the RCC or HWD was notified there should be documentation that the resident was out of medication. Attempted telephone interview with Resident #4's primary care physician on 01/27/22 at 9:36am and was unsuccessful. 2. Review of Resident #1 current FL-2 dated 10/05/21 revealed:	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 -Diagnoses included spinal stenosis and bone disorder. -There was an order for Tramadol 50mg, 1 tablet twice a day (Tramadol is a medication used to treat chronic pain). Review of Resident #1's physician order dated 12/16/21 revealed there was an order for Tramadol 50mg, 1 tablet twice a day as needed for pain. Review of Resident #1's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Tramadol 50mg, give one tablet two times a day, scheduled for administration at 6:00am and 6:00pm. -Tramadol 50mg was documented as administered twice a day from 12/01/21 to 12/31/21. -The Tramadol order was not changed twice a day as needed, as ordered on 12/16/21. Review of Resident #1's January 2022 eMAR revealed: -There was an entry for Tramadol 50mg, give one tablet two times a day, scheduled for administration at 6:00am and 6:00pm. -Tramadol 50mg was documented as administered twice a day from 12/01/21 to 12/31/21. -The Tramadol order was not changed twice a day as needed, as ordered on 12/16/21. Interview with the Resident Care Coordinator (RCC) on 01/27/22 at 9:45am revealed: -Resident #1's primary care provider sent an electronic script to the pharmacy on 12/16/21. -It was the responsibility of the medication aide (MA) that removed the order from the fax to enter	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 15 the order into the electronic records. -The RCC or the Health and Wellness Director (HWD) was responsible to ensure that the MA entered the order correctly. -He was not sure who removed the order from the fax machine on 12/16/21 and he was not aware that the order had changed for Tramadol to switch from scheduled twice a day to as needed twice a day. Interview with the Administrator on 01/27/22 at 2:33pm revealed: -She expected Resident #1's order to be correct for Tramadol. -It was the RCC and HWD responsibility to ensure that MA enter order changes correctly. -She was not aware that Resident #1's Tramadol order was not modified on 12/16/21 as ordered. Interview with Resident #1's primary care provider (PCP) on 01/27/22 at 9:57am revealed she expected medication orders to be accurately implemented on Resident #1 including his Tramadol. Attempted interview with Resident #1's hospice agency on 01/27/22 at 1:50pm was unsuccessful. Based observations and interviews, it was determined that Resident #1 was not interviewable.	{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	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 371	Continued From page 16	D 371		

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 infection control measures were implemented during the medication pass on 01/26/22 by 1 of 2 medication aide observed who failed to wash or sanitize their hands between administering medication to multiple residents.

The findings are:

Review of the facility's General Guidelines for Medication Administration dated June of 2020 revealed:
-Infection control and prevention practices based on the Center for Disease Control and Prevention (CDC) guidelines for hand hygiene, associates should wash their hands or use hand sanitizer prior to medication administration for each resident.
-Handwashing should be performed with soap and water and not with the use of sanitizer solution when hands are visibly dirty.
-Hand sanitizer should be stored in the medication cart drawers.

Observation of the medication aide (MA) administering morning medications in the hallway of the Special Care Unit (SCU) on 01/26/22 from 8:33am to 9:25am revealed:
-There was no hand sanitizer on the medication cart but there was a wall hanging hand sanitizer dispenser on the wall across from the medication cart.
-The MA returned to the medication cart after administering medications to a resident in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 371	Continued From page 17 hallway at 8:36am. -The MA did not perform handwashing before she began preparing medications for a second resident. -The MA donned gloves to crush medications for the second resident but did not perform handwashing before at 8:59am. -The MA did not perform hand hygiene after removing her gloves and administering the resident's medications. -The MA returned to the medication cart at 9:06am and did not perform hand hygiene after administering the second resident's medications. -The MA went into the medication room to retrieve a nutritional supplement for a third resident at 9:08 and she did not perform hand hygiene before or after giving the resident the nutritional supplement. -The MA returned to the medication cart to prepare medications for a begin preparing medications for a fourth resident at 9:10am and did not perform hand hygiene before or after preparing the medications. -The MA administered the medications at 9:16am and returned to the medication cart at 9:25am after she administered the medications to the fourth resident and did not perform hand hygiene. Observation of the medication aide (MA) administering 12:00pm medications in the hallway of the Special Care Unit (SCU) on 01/26/22 from 11:20am to 11:35am revealed: -The MA was preparing medications for a resident at the medication cart at 11:20am. -The MA did not perform hand hygiene before she began preparing the medications for the resident. -The MA administered the resident's medications at 11:28am and returned to the cart at 11:32am. -The MA did not perform hand hygiene after she administered the medications for the resident.	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 371	Continued From page 18 Interview with the MA that was observed not performing hand hygiene during the medication pass on 01/26/22 11:35am revealed: -She started working at the facility in March of 2021 as a personal care aide (PCA) and became a MA in December 2021. -There was no hand sanitizer on or in the medication cart. -She was aware that she needed to wear gloves to prepare crushed medications or give injections, but she was not aware that she had to wash her hands using sanitizer or soap and water in between administering each residents' medications. -She received her medication aide training and infection control training at the facility with the Health and Wellness Director (HWD) but did not recall that hand hygiene was to be performed before and after medication administration of each resident. Interview with the Resident Care Coordinator (RCC) on 01/26/22 at 11:46am revealed: -He expected MAs to perform hand hygiene at least between each resident and more frequently if needed. -If hand hygiene was not performed properly there was risk for contamination and infection. Interview with the Health and Wellness Director (HWD) on 01/26/22 at 11:55am revealed: -She expected hand hygiene to be performed in between each resident during medication administration. -She taught the infection control class for the MA that did not perform hand hygiene and was certain that hand hygiene was covered during that class.	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 371	Continued From page 19 Interview with the Administrator on 01/26/22 at 12:20pm revealed she expected MAs to perform hand hygiene at least in between each resident during medication pass to prevent the risk for cross contamination and spread of infection.	D 371		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local county health department (LHD) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding visitor and resident screening of temperatures	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 612	Continued From page 20	D 612		

and COVID-19 symptoms, and social distancing of residents when dining.

The findings are:

Review of North Carolina Department of Health and Human Services (NC DHHS) COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 11/19/21 revealed:
-All staff should be screened for symptoms prior to every shift, all residents should be screened for symptoms daily and all visitors should be screened for symptoms prior to entering the facility.

Review of an email from the local health department (LHD) to the facility on 01/25/22 revealed reference material including NC DHHS COVID-19 Infection Prevention guidance for Long-Term Care Facilities website link.

Review of CDC Guidance Interim Infection Prevention and Control Recommendations to COVID-19 spread in Nursing Homes & Long-Term Care Facilities dated 09/10/21 revealed:
-Evaluate residents at least daily for fever and symptoms consistent with COVID-19.
-Visitors shall be screened upon entrance to the community including symptoms such as fever, chills, cough, shortness of breath, fatigue, headache, body or muscle aches, loss of taste or smell, sore throat, congestions, nausea, vomiting, diarrhea.
-Visitors shall be screened upon entrance to the community for a positive COVID-19 test and close contact with someone with COVID-19.

Review of NC DHHS Best Practices for Infection Prevention in Post-Acute Care Facilities dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 612	Continued From page 21 10/28/21 revealed facilities shall modify layout to encourage social distancing. Review of the facility's Communicable Disease Control policy dated 11/2021 revealed: -The Health and Wellness Director (HWD) was responsible for monitoring infections on an ongoing basis to assist in the prevention, transmission, and mitigation of communicable disease infection. -Residents and staff will be made aware of ways to prevent and reduce the spread of infectious disease including reporting of symptoms of illness; see COVID-19 Screening Log Policy for screening for signs and symptoms of COVID-19. -Prevention and awareness will occur through in-services, meetings, internal communications, signage for visitors, outside vendors, private duty caregivers, and assigned infection control learning management system courses. -The facility should limit the number of entrances for visitor and vendors to enhance screening and provide direction on infection control measures. -Separate confidential lists of resident's and staff with symptoms of the disease should be maintained and tracked to monitor the course of the disease and outcomes. -Social distancing measures are essential in containing communicable disease outbreaks; an example includes dining restrictions in individual rooms or using 6 feet distances between residents as directed by local or state health departments. Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 76 beds including a Special Care Unit (SCU) with a capacity of 24 beds. Review of the facility's resident census report	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 612	Continued From page 22 dated 01/26/22 revealed there was a census of 16 residents on the SCU and 35 residents on the assisted living. Interview with the Health and Wellness Director (HWD) on 01/26/22 at 8:15am revealed: -There were 3 residents on the Assisted Living (AL) unit that were positive for COVID-19. -The first resident was diagnosed with COVID-19 on 01/20/22. -Two additional residents were diagnosed with COVID-19 on 01/22/22. -The three residents that had COVID-19 sat at the same table every day during meals but were now eating meals in their rooms during their quarantine. Interview with the Administrator on 01/27/22 at 9:31am revealed: -A staff member tested positive for COVID-19 on 12/22/21. -A second staff member tested positive for COVID-19 on 01/07/22. -A third staff member tested positive for COVID-19 on 01/08/22. -A fourth staff member tested positive for COVID-19 on 01/11/22. -A fifth staff member tested positive for COVID-19 on 01/15/22. -A sixth staff member tested positive for COVID-19 on 01/18/22. -A seventh staff member tested positive for COVID-19 on 01/19/22. -An eighth staff member tested positive for COVID-19 on 01/26/22. -The facility performed testing based on instruction from the District Director of Clinical Services. 1. a. Observation of the entrance to the facility on	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 612	Continued From page 23 01/19/22 at 8:00am revealed: -A medication aide (MA) allowed the survey team to enter the front foyer. -A surveyor asked the MA if the survey team needed to be screened prior to entry. -The MA directed the survey team to take their temperatures with a thermometer attached to the wall and to document their temperatures in a binder at the receptionist counter. -One surveyors temperature read at 89.9 degrees and was recorded in the logbook. -A second surveyor was unable to obtain an accurate temperature reading on 5 attempts; the thermometer read "Lo." -The third surveyor obtained a temperature reading of 90.3 degrees on the 6th attempt and documented in the facility logbook. Review of the facility's COVID-19 Screening Log for Associates and Essential Healthcare Providers revealed: -The Screening Log was dated 06/2021 and listed the expectation of staff were to screen before their work shift. -At the top of the Screening Log was a title with "state and local health department guidance on screenings supersedes this document." -The 1st column directed to document the date. -The 2nd column directed to document the time. -The 3rd column directed to document the name. -The 4th column directed to document the temperature. -The 5th column directed to document if any of the COVID-19 symptoms in the past 48 hours had been experienced. (There was no list of symptoms present in the binder). -The 6th column directed to document if there had been any prolonged contact (within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24 hour period) with	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 612	Continued From page 24	D 612		

someone with COVID-19 in the prior 14 days or otherwise met the criteria for quarantine?
A recent diagnosis of COVID-19 or suspected positive COVID-19 (i.e. confirmed positive test or, diagnosed with COVID-19 by a healthcare professional? Check yes or no.
-The 7th column: if you answered yes to any questions, notify the Executive Director (ED) for entry/reentry decision and refer to Healthcare Professional.
-The 8th column: Outcomes (Indicate No or Yes) Access to the community allowed (yes or no).

Telephone interview with a resident's family member on 01/27/22 at 2:20pm revealed:
-He rarely went to the facility because he worked daily with COVID-19 patients as a Medical Physician at the local hospital.
-He previously visited the facility prior to December 2021 and upon entering he was not asked to screen or take his temperature but because of his knowledge of COVID-19, he used the wall thermometer to take his temperature and used the log book to sign in.
-He recorded his name, temperature and noted "immunized" on the sign in sheet.

Telephone interview with the District Director of Clinical Services on 01/26/22 at 2:18pm revealed:
-She was not aware that the COVID-19 Logbook for visitors and staff did not list the symptoms for COVID-19.
-She was not aware that the wall thermometer was not functioning properly for visitors to take their temperatures.

b. Review of the residents' records revealed there was no documentation of resident's temperatures and screening for COVID-19 symptoms daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 612	Continued From page 25 Interview with a medication aide (MA) on 01/27/22 at 9:55am revealed the facility was not taking resident's temperatures daily or documenting screening of COVID-19 symptoms as per instructions from the Health and Wellness Director (HWD). Interview with the HWD on 01/26/22 at 11:48am revealed: -She received instructions and guidance on COVID-19 resident screening from the District Director of Clinical Services. -The District Director of Clinical Services directed her in July 2021 to stop taking daily temperatures of residents. -The facility had not taken daily temperatures of residents to assess for COVID-19 since July 2021. -Staff monitored residents for symptoms of COVID-19 but did not document anywhere that they monitored for symptoms. Interview with the Administrator on 01/26/22 at 12:23pm revealed: -Clinical staff had not taken resident temperatures daily since July 2021 as directed by the District Director of Clinical Services after all residents had been vaccinated. -She was not aware that clinical staff should take residents temperatures every day to monitor for COVID-19 symptoms. -She notified the LHD of positive COVID-19 residents on 01/24/22 by leaving the required voicemail with detailed information and sent an email to the LHD on 01/24/22. -She received an email response back from the LHD on 01/25/22 which provided links to guidance from NC DHHS and CDC guidance. -She and the HWD had not looked up the links provided in the email for specific guidance on	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 612	Continued From page 26 screening COVID-19 residents. Telephone interview with the District Director of Clinical Services on 01/26/22 at 2:18pm revealed: -The facility had stopped checking residents' daily temperatures and screening for COVID-19 symptoms in July 2021. -She could not remember exactly why the facility had stopped taking residents daily temperatures or screening for COVID-19 symptoms. -She could not recall that any resident was ever positive for COVID-19 when staff used to complete the daily temperature and scene for COVID-19 symptoms. -To her knowledge staff had continued to monitor residents for COVID-19 symptoms but did not think that staff had a system to document. Telephone interview with the LHD nurse on 01/26/22 at 12:39pm revealed: -The facility should check resident temperatures and check for COVID-19 symptoms daily to prevent an outbreak. -She provided the Administrator with links to NC DHHS and CDC for the most recent guidance on COVID-19 that discusses daily monitoring for residents of COVID-19 symptoms. -She also provided the Administrator an email with the Regional Prevention Support (RPS) Coordinator contact information to contact with infection control assistance and/or questions in managing COVID-19. 2. Observation of the main assisted living (AL) dining room on 01/26/22 at 8:05am revealed: -There were 11 residents and 2 staff in the room. -The residents were seated less than 6 feet apart at the tables. Observation of the main AL dining room on	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 612	Continued From page 27 01/27/22 at 12:53pm revealed: -There were three residents in wheelchairs seated at one table. -The three residents were approximately 2 feet apart from each other. -There was one staff person in the dining room observing residents and did not attempt to social distance the three residents at the table. Telephone interview with the District Director of Clinical Services on 01/26/22 at 2:18pm revealed: -Residents who tested positive for COVID-19 should be dining in their individual rooms. -Any resident that tested negative for COVID-19 and ate in the dining room should be socially distanced. -It was the staff's responsibility to ensure that residents were socially distanced in the dining room.	D 612		
D 618	10A NCAC 13F .1802 (a) Report & Notification of a Outbreak (temp) 10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK (a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in Rules 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments.	D 618		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 618	Continued From page 28 This Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to report staff members that tested positive for COVID-19 to the local health department (LHD). The findings are: Review of CDC Guidance Interim Infection Prevention and Control Recommendations to COVID-19 spread in Nursing Homes & Long-Term Care Facilities dated 09/10/21 revealed the facility shall notify the health department promptly of 1 or more resident or staff with suspected or confirmed COVID-19. Telephone interview with the LHD nurse on 01/26/22 at 12:39pm revealed: -She was not aware that staff members had tested positive at the facility. -She expected to be notified of all staff members and residents that tested positive for COVID-19 at the facility so that she could provide guidance for testing and guidelines during outbreak status. Interview with the Administrator on 01/27/22 at 9:31am revealed: -She did not notify the LHD of the staff members that tested positive for COVID-19 because she was not aware that she needed to. -A staff member tested positive for COVID-19 on 12/22/21. -A second staff member tested positive for COVID-19 on 01/07/22. -A third staff member tested positive for COVID-19 on 01/08/22. -A fourth staff member tested positive for COVID-19 on 01/11/22. -A fifth staff member tested positive for COVID-19 on 01/15/22.	D 618		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 618	Continued From page 29 -A sixth staff member tested positive for COVID-19 on 01/18/22. -A seventh staff member tested positive for COVID-19 on 01/19/22. -An eighth staff member tested positive for COVID-19 on 01/26/22. Telephone interview with the District Director of Clinical Services on 01/26/22 at 2:18pm revealed: -She expected the Administrator or Health and Wellness Director (HWD) to notify the LHD of any positive cases of COVID-19 in the facility. -She received her COVID-19 guidance from the Center for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS). -She was not aware that the Administrator or HWD had not reported the staff members that tested positive for COVID-19.	D 618		
D 619	10A NCAC 13F .1802 (b) Report & Notification of a Outbreak (temp) 10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK (b) The facility shall inform the residents and their representative(s) and staff within 24 hours following confirmation by the local health department of a communicable disease outbreak, or one or more confirmed cases of COVID-19 among any resident or staff person. The facility, in its notification to residents and their representative(s), shall: (1) not disclose any personally identifiable information of the residents or staff; (2) provide information on the measures the	D 619		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 619	Continued From page 30	D 619		

facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change;
(3) provide weekly updates until the communicable illness within the facility has resolved, as
determined by the local health department; and
(4) provide education to the resident(s) concerning measures they can take to reduce the risk of
spread or transmission of infection.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to inform residents and their representatives within 24 hours following one or more confirmed cases of COVID-19 among any resident or staff person.

The findings are:

Review of CDC Guidance Interim Infection Prevention and Control Recommendations to COVID-19 spread in Nursing Homes & Long-Term Care Facilities dated 09/10/21 revealed the facility shall notify healthcare providers, residents and families promptly about identification of COVID-19 in the facility and maintain ongoing and frequent communication with residents and families with updates on the situation and facility's actions.

Interview with the Health and Wellness Director (HWD) on 01/26/22 at 8:15am revealed:
-There were 3 residents on the Assisted Living (AL) unit that were positive for COVID-19.
-The first resident was diagnosed with COVID-19 on 01/20/22.
-Two additional residents were diagnosed with COVID-19 on 01/22/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 619	Continued From page 31 Interview with the Administrator on 01/27/22 at 9:31am revealed: -A staff member tested positive for COVID-19 on 12/22/21. -A second staff member tested positive for COVID-19 on 01/07/22. -A third staff member tested positive for COVID-19 on 01/08/22. -A fourth staff member tested positive for COVID-19 on 01/11/22. -A fifth staff member tested positive for COVID-19 on 01/15/22. -A sixth staff member tested positive for COVID-19 on 01/18/22. -A seventh staff member tested positive for COVID-19 on 01/19/22. -An eighth staff member tested positive for COVID-19 on 01/26/22. Telephone interview with Resident #4's family member on 01/27/22 at 2:20pm revealed: -He had not received notification that the facility had COVID-19 positive residents and staff and they were currently in outbreak status. -He spoke to the Health and Wellness Director (HWD) on 01/24/22 regarding his family members medication and was told that the Resident Care Coordinator (RCC) was currently out of work due to a COVID-19 diagnosis. -He would have expected to have been notified if the facility was in COVID-19 outbreak status due to the possibility of him visiting. Telephone interview with a second resident's family member on 01/26/22 at 4:25pm revealed he was not made aware that there was currently COVID-19 in the facility. Interview with the Administrator on 01/27/22 at	D 619		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(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 619	Continued From page 32 10:22am revealed she did not notify the resident's family members that there was COVID-19 in the facility because she was not aware that she was required to.	D 619		