STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The adult care licensure section conducted an annual and follow-up survey between 11/09/21 and 11/15/21 with 11/12/21 being a desk review and a telephone exit on 11/15/21.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled staff (Staff D) had a test for tuberculosis (TB) upon hire. The findings are: Review of Staff D's, medication aide (MA), personnel record revealed: -She was hired as a MA on 07/12/21. -There was no documentation of a TB skin test, chest x-ray or a baseline symptom screening form for TB completed prior to working at the facility. Telephone interview with the business office manager (BOM) on 11/15/21 at 3:20pm revealed: -It was her responsibility to ensure staff had a TB	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 131	Continued From page 1 test completed before hire. -The documentation was to be kept in the employee's file. -She thought Staff D had her TB test done but she did not have a copy of the results in her employee file. Telephone interview with the Executive Director (ED) on 11/15/21 at 3:55pm revealed the BOM was responsible to ensure staff TB tests were completed and results kept in the employees file. Attempted telephone interview with Staff D on 11/15/21 at 3:35pm was unsuccessful.	D 131		
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: TYPE B VIOLATION Based on interviews, observation and record reviews the facility failed to ensure the implementation of procedures and treatments as ordered by the physician for 2 of 6 sampled residents related to an order for oxygen saturation levels with as needed (PRN) oxygen (Resident #5) and an order for weights to be taken twice a week to monitor fluid overload (Resident #6).	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 2 The findings are: 1.Review of Resident #5's current FL2 dated 03/11/21 revealed: -Diagnoses included high blood pressure, atrial fibrillation, coronary heart disease and hyperlipidemia. -An assisted living facility was the recommended level of care. Review of Resident #5's Care Plan dated 04/30/21 revealed: -She was independent with all activities of daily living (ADLs). -There was no documentation about the use of oxygen. Review of Resident #5's record revealed there was not a licensed health professional support (LHPS) evaluation. Review of Resident #5's primary care provider's (PCP) orders dated 04/21/21 revealed: -An order to apply oxygen via nasal cannula (NC) at 2 liters if her oxygen saturations were less than 90%. -An order to monitor vital signs every 4 hours and notify the PCP if Resident #5's oxygen saturations were less than 90%. Review of Resident #5's PCP order dated 05/19/21 revealed to continue daily vital sign monitoring. Telephone interview with the Registered Nurse (RN) at Resident #5's PCP's office on 11/12/21 at 9:12am revealed vital sign monitoring included: oxygen saturation levels, blood pressure, heart rate, respiratory rate and temperature.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 3 Review of Resident #5's Emergency Department (ED) discharge paperwork dated 08/04/21 revealed: -Resident #5 was short of breath and hypoxic (an abnormally low concentration of oxygen in the blood) on arrival to the ED with a oxygen saturation of 88%. -She was put on 2 liters of oxygen via NC and her oxygen saturation increased to 98%. Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed: -There was not an entry to document daily oxygen saturation levels. -There was an entry to document PRN oxygen saturation levels but there was no documentation from 09/01/21- 09/30/21. Review of Resident #5's October 2021 eMAR revealed: -There was not an entry to document daily oxygen saturation levels. -There was an entry to document PRN oxygen saturation levels but there was no documentation from 10/01/21 - 10/31/21. Review of Resident #5's November 2021 eMAR revealed: -There was not an entry to document daily oxygen saturation levels. -There was an entry to document PRN oxygen saturation levels but there was no documentation from 11/01/21- 11/09/21. Interview with Resident #5 on 11/10/21 at 1:15pm revealed: -She had a pulse oximeter (a device used to measure the amount of oxygen in the blood) in	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 4	D 276		

her room and checked her oxygen saturations "sometimes" but did not document her oxygen saturations.
-Staff at the facility did not test her oxygen saturation.
-Staff did not ask her to report her oxygen saturation values to them.
-She only wore oxygen at night and she thought her oxygen tank was empty.
-She reported the empty oxygen tank to a medication aide (MA) this morning (11/10/21).

Interview with a first shift MA on 11/10/21 at 1:30pm revealed:
-Resident #5 only wore oxygen at night.
-There was not an order on the eMAR for staff to check daily oxygen saturations.
-This morning (11/10/21) Resident #5 told her the oxygen concentrator was broken.
-She documented the status of Resident #5's oxygen concentrator in a book on the medication cart as well as informed the Health and Wellness Coordinator (HWC).

Telephone interview with a second shift MA on 11/15/21 at 3:01pm revealed:
-Resident #5 complained of shortness of breath on 11/11/21 while her daughter was visiting.
-Resident #5's daughter stated she would make an appointment with her PCP.
-Resident #5 did not wear oxygen during the day but she did wear it at night.
-Staff were supposed to check Resident #5's oxygen saturations if she was short of breath and contact Resident #5's PCP if her saturations were below 93%.
-She did not remember what Resident #5's oxygen saturation was on 11/11/21 but she did not contact the PCP.
-Checking residents' oxygen saturations when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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		

they were short of breath had been a standard practice for all residents since COVID-19 started.
-Resident's oxygen saturations should have been greater than 93%.
-Resident #5 did not have an order on her eMAR to check her oxygen saturations.

Interview with the HWC on 11/10/21 at 3:40pm revealed:
-She checked on Resident #5 this afternoon (11/10/21) after she was informed of her oxygen saturation level of 86%.
-Resident #5 reported to her she had checked her own oxygen saturation level after she walked to her room.
-It was normal for Resident #5's oxygen saturation levels to drop after walking.
-She did not recommend that Resident #5 put on her oxygen after walking.
-Resident #5 reported feeling well and had a oxygen saturation level of 93% when the HWC checked.
-No one told her that Resident #5's oxygen concentrator was broken.
-Staff did not routinely check Resident #5's oxygen saturation levels because the facility did not have an order.
-Resident #5's PCP sent a new order to the facility earlier that afternoon (11/10/21) to apply 2 liters of NC if oxygen saturation levels are less than 92% or resident is short of breath.
-Staff were to check Resident #5's oxygen saturation levels if they saw her exhibiting signs of shortness of breath.

Telephone interview with the Registered Nurse (RN) at Resident #5's PCP's office on 11/12/21 at 9:12am revealed:
-The facility should have checked Resident #5's vital signs as well as weights on a weekly basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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	D 276		

-The office should have been notified if any of her vitals were out of the normal ranges.

Telephone interview with the RN at Resident #5's PCP's office on 11/15/21 at 11:12am revealed:
-The facility should have applied oxygen to Resident #5 if her oxygen saturation levels were low, after walking or when she was resting.
-An oxygen saturation level less than 90% is considered hypoxemia.
-If she showed signs of distress such as shortness of breath or difficulty breathing then she should have been evaluated by a provider.

Interview with the District Director of Clinical Services on 11/10/21 at 1:40pm revealed:
-The previous Health and Wellness Director (HWD) entered Resident #5's oxygen saturation order into the eMAR incorrectly.
-No one verified the entries that the HWD put on the eMAR.
-She was not aware Resident #5's oxygen saturation order was entered incorrectly on the eMAR.
-Since the order was entered as PRN, the staff have not been checking her oxygen saturation levels.

Telephone interview with the Executive Director on 11/15/21 at 3:55pm revealed:
-The previous HWD was responsible for putting new orders on the eMAR.
-No one verified the orders she put on the eMAR or audited treatment orders on the eMAR.
-She was not aware that Resident #5's oxygen saturation level order was entered incorrectly on the eMAR.
-She would expect the HWD to enter orders correctly on the eMAR.
-She was not aware Resident #5's oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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	D 276		

concentrator was broken.
-She would expect the staff member that was informed of the broken concentrator to contact the oxygen company immediately for a replacement part.

Attempted telephone interview with Resident #5's family member was unsuccessful on 11/09/21 at 2:20pm and 11/15/21 at 1:45pm.

2. Review of Resident #6's current FL2 dated 10/13/21 revealed:
-Diagnoses included alzheimer dementia, chronic obstructive pulmonary disease (COPD), primary hypertension and generalized edema.
-The level of care was documented as the special care unit (SCU).

Review of Resident #6's physician's order dated 10/16/21 revealed:
-There was an order for the resident to be weighed twice weekly on Wednesday and Saturday before breakfast.
-Notify the physician if the weight gain was greater than 5 pounds (lbs).

Review of Resident #6's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry to weigh Resident #6 twice weekly from 10/16/21 through 10/31/21 and notify the physician if the weight gain was greater than 5lbs.
-There was no documentation of Resident #6's weights twice weekly from 10/16/21 through 10/31/21.
-Resident #6's weights were not documented on the eMAR 5 of 5 possible opportunities.

Review of Resident #6's facility's progress notes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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	D 276		

dated 10/16/21 through 10/31/21 revealed:
-There was no documentation a new order had been received from the primary care physician (PCP) to weigh the resident twice weekly before breakfast, and notify the physician if the weight gain was greater than 5lbs.
-There was no documentation of the resident's weights twice weekly from 10/16/21 through 10/30/21.
-There was no documentation the primary care physician (PCP) was notified.

A request was made for documentation of Resident #6's weights recorded twice weekly, from 10/16/21 through 10/30/21, and was not provided prior to survey exit on 11/15/21.

Review of Resident #6's November 2021 eMAR revealed:
-There was an entry to weigh the resident twice weekly from 11/03/21 through 11/13/21 and notify the physician if the weight gain was greater than 5lbs.
-There was no documentation of Resident #6's weights twice weekly from 11/03/21 through 11/13/21.
-Resident #6's weights were not documented on the eMAR 4 of 4 possible opportunities.

Review of the facility's progress notes dated 11/01/21 through 11/13/21 revealed:
-On 11/03/21, it was documented both of Resident 6's legs were swollen and leaking fluid, she was having difficulty with ambulation, unable to lift her legs to lay down and complained of tenderness to the touch.
-On 11/04/21, it was documented Resident 6's legs were red and leaking fluid.
-On 11/06/21, there was documentation the resident continued to have swelling in both of her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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	D 276		

legs and could not bear any weight while walking.
-There was no documentation of the resident's weights on 11/03/21 through 11/13/21.
-There was no documentation Resident 6's PCP was notified.

A request was made for documentation of Resident #6's weights twice weekly, from 11/03/21 through 11/13/21, and was not provided prior to survey exit on 11/15/21.

Interview with the first shift special care unit (SCU) medication aide (MA) on 11/10/21 at 12:40pm revealed:
-She administered medications to Resident #6.
-At the time of the morning medication pass, the eMAR displayed on the dashboard screen a list of medications and treatment for each resident with directions for administration and the times entered.
-There was not a snapshot of the residents eMARs showing the weekly/monthly view of the complete medication profile and the initials of the MAs when the weight order was completed.
-If the treatment was not displayed on the dashboard at the time of the medication pass, there was no indication to the MA that it was a current order.
-If a medication or treatment was missed during the medication pass, it would be highlighted in red for ongoing shifts until there was a response to the order on the dashboard.
-Resident #6's weights on Wednesday and Saturday was not listed on the dashboard to be taken on the days she worked.
-She did not know why an order that was entered on the eMAR would not show up on the dashboard.
-She did not know Resident #6 had an order to be weighed twice weekly on Wednesday and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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	D 276		

Saturday before breakfast, and notify the physician if the weight gain was greater than 5 lbs.

Interview with a second first shift SCU MA on 11/10/21 at 1:15pm revealed:
-She administered medications to the residents in the SCU.
-The order for Resident #6 to be weighed on Wednesday and Saturday and notify the physician for a weight gain of greater that 5 lbs was displayed on the dashboard this morning.
-She had not seen the order during the morning medication pass for Resident #6 prior to 11/10/21.
-She did not know the order had been on the eMAR since 10/16/21.
-She could only administer medications and treatments that were displayed on the dashboard at the scheduled time.
-She had not weighed Resident #6 twice weekly prior to 11/10/21.
-She had not observed any increased swelling or shortness of breath with the resident.

Telephone interview with Resident #6's primary care physician (PCP) on 10/11/21 at 4:45pm revealed:
-She had ordered weights to be taken on Wednesday and Saturday and to contact her if the weight gain was greater than 5 lbs.
-She increased the weights to twice weekly due to a recent round of hospital related visits for kidney issues.
-Resident #6's diuretics, previously prescribed for fluid overload, were discontinued to address the kidney issues.
-There were concerns the resident could develop fluid overload without the diuretics, and she should be monitored more closely for an increase in swelling and an increase in weight.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 11	D 276		

-She had been contacted by the Health and Wellness Coordinator (HWC) over the past few weeks regarding the increased edema in the resident's legs.
-She did not know the facility staff had not been monitoring the resident's weight twice weekly and notifying her of an increase of 5lbs or more.
-She would expect the staff to follow her orders for the residents.

Interview with the HWC on 11/10/21 at 2:26pm revealed:
-She had entered Resident #6's order on 10/16/21 to be weighed twice weekly on Wednesday and Saturday before breakfast, and notify the physician if the weight gain was greater than 5 lbs.
-She identified Wednesday and Saturday as the two days to weigh the resident in the order entry.
-She did not know why the order to weigh the resident did not populate to the dashboard on Wednesday and Saturday for the MAs to view.
-She did not review the eMARS after an order was entered.
-She did not know Resident #6 was not weighed twice weekly.
-The MAs recorded the residents' weights on the eMARS monthly or as ordered.
-She did not have any additional documentation of the resident's weights.

Interview with the District Director of Clinical Services on 11/10/21 at 11:25am revealed:
-She provided clinical support to this facility and several other communities.
-The Health and Wellness Director (HWD) or the HWC should be reviewing the report daily, or as frequently as possible, identifying "holes" in the eMARS.
-A "hole" is the absence of documentation on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 12	D 276		

eMAR for a medication or treatment without a documented explanation
-The previous HWD was responsible for reviewing the eMARs and identifying any "holes" in the documentation of administration of medications or treatments.
-She understood these tasks were completed by the previous HWD.
-She did not know if the HWC was reviewing this report in the absence of the HWD.

Telephone interview with the Executive Director (ED) on 11/15/21 at 3:55pm revealed:
-The HWC and the MAs entered orders on the eMARS in the absence of the HWD.
-The previous HWD had been reviewing the eMARS for medications or treatments were missed.
-She did not know if the HWC was performing this task in the absence of an HWD.
-She did not know the order for Resident #6 to have her weights checked twice weekly had not populated onto the dashboard for the MAs to view.
-She did not know Resident #6 had not been weighed twice weekly as ordered by her physician since 10/16/21.

Based on observations, interviews and record review it was determined Resident #6 was not interviewable.

_____

The facility failed to ensure physician orders were implemented for a resident with orders for oxygen saturation levels and as needed oxygen increasing the risk of low blood oxygen levels and shortness of breath (Resident #5) and an order for weights twice weekly increasing the risk of swelling in the legs and difficulty walking (Resident #6). The facility's failure was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 13 detrimental to the health of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G S 131D-34 on 11/10/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 30, 2021.	D 276		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood	D 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 278	Continued From page 14 samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance;	D 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 278	Continued From page 15 (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to ensure a licensed health professional provided an onsite health evaluation for 1 of 5 sampled residents (Resident #5) who had a physician's order for oxygen via nasal cannula if her oxygen saturation levels dropped below 90%. Review of Resident #5's current FL2 dated 03/11/21 revealed: -Diagnoses included atrial fibrillation, high blood pressure, coronary artery disease, hyperlipidemia and memory impairment. -Recommended level of care was an assisted living facility. Review of Resident #5's Care Plan dated 04/30/21 revealed: -She was independent with all activities of daily living (ADLs). -There was no documentation about the use of oxygen. Review of the facility's Physician Communication	D 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 278	Continued From page 16	D 278		

Sheet for Resident #5 dated 04/21/21 revealed:
-Resident #5 had been complaining of shortness of breath.
-The primary care provider (PCP) provided an order to apply oxygen via nasal cannula (NC) at 2 liters if her oxygen saturations were less then 90%.
-An order to monitor vital signs every 4 hours and notify the PCP if Resident #5's oxygen saturations were less than 90%.

Review of Resident #5's Emergency Department (ED) discharge paperwork dated 08/04/21 revealed:
-Resident #5 was short of breath and hypoxemic (an abnormally low concentration of oxygen in the blood) on arrival to the ED with a oxygen saturation of 88%.
-She was put on 2 liters of NC and her oxygen saturation improved to 98%.

Observation of Resident #5 on 11/10/21 at 1:15pm revealed:
-She sat in a chair while she looked at a magazine.
-Her chest visibly rose and fell with each breath she took.
-Her breathing was audible.
-She appeared short of breath.

Interview with Resident #5 on 11/10/21 at 1:30pm revealed:
-She was having more difficulty breathing today than she did on most days, but she had not told anyone.
-She wore oxygen at night and her tank ran out of oxygen 1 night ago.
-She had a pulse oximeter (device used to measure the amount of oxygen in the blood) in her room and tested her oxygen saturations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 278	Continued From page 17	D 278		

"sometimes" during the day.
-She did not record her oxygen saturations or tell the staff her saturations.
-She only wore her oxygen while she slept at night.

Observation of Resident #5 on 11/10/21 at 1:19pm revealed while on room air, she put on her pulse oximeter and it read an oxygen saturation of 86%.

Interview with a medication aide (MA) on 11/10/21 at 1:30pm revealed:
-She had never taken Resident #5's oxygen saturation level.
-Resident #5 had an as needed (PRN) order to wear oxygen if oxygen saturation levels were less than 90%.
-The order did not specify to check Resident #5's oxygen saturation if she was short of breath.
-She had not observed Resident #5 wear oxygen during the day.
-Resident #5 only wore oxygen at night.

Review of Resident #5's record revealed there was not a licensed health professional support (LHPS) evaluation.

Interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:45am revealed:
-She was aware that Resident #5 wore oxygen at night.
-She was a licensed practical nurse (LPN).
-That the Health and Wellness Director (HWD) was responsible for completing the LHPS evaluations.
-The facility's HWD recently left and the facility did not have a current HWD.
-She was not sure who was responsible for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 278	Continued From page 18	D 278		

completing the LHPS evaluations in the HWD's absence.

Telephone interview with Resident #5's current PCP's Registered Nurse (RN) on 11/15/21 at 11:12am revealed:
-Resident #5 started seeing this provider on 05/13/21.
-The current PCP continued her previous PCP's oxygen orders.
-Oxygen saturation levels below 90% made Resident #5 hypoxemic and the facility should apply 2 liters of NC.

Interview with the District Director of Clinical Services on 11/10/21 at 11:24am revealed:
-The HWD was responsible for completing the LHPS evaluations.
-The facility's HWD recently left and the facility did not have a current HWD.
-She and the Executive Director (ED) were responsible for ensuring that the HWD tasks were completed while the position was open.
-She was under the impression that all of the residents' paperwork was up to date prior to the previous HWD's exit.

Telephone interview with the ED on 11/15/21 at 3:55pm revealed:
-The HWD was responsible for completing the LHPS evaluations.
-Since the facility did not have a current HWD, a corporate clinical partner completed the LHPS evaluations.
-The corporate clinical partner was given a list of new admissions and a list of residents that had new LHPS tasks to complete evaluations.
-No one audited the residents' records to ensure all LHPS evaluations were complete after the previous HWD left.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 278	Continued From page 19 -She was not aware that Resident #5 did not have a LHPS evaluation for her oxygen use. _____ The facility failed to ensure Resident #5 was evaluated by a Registered Nurse related to the administration of oxygen and monitoring of her oxygen use. The facility's failure to ensure proper use of oxygen was detrimental to the health and safety of Resident #5 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G S 131D-34 on 11/10/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 30, 2021. _____	D 278		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 344	Continued From page 20	D 344		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to clarify medication orders with the primary care provider, for 2 of 4 residents (Residents #6 and #7) observed during the medication pass related to an eye medication used to treat conjunctivitis and a medication for a vitamin deficiency (#7), and a medication to treat gastric discomfort (#6).

The findings are:

The medication error rate was 3% as evidenced by the observation of 1 error out of 32 opportunities during the 9:00am -10:00am medication pass on 11/09/21.

1. Review of Resident #7's current FL2 dated 03/17/21 revealed:
- Diagnoses included a major depressive disorder, hypertension, transient ischemic attack (TIA) and chronic obstructive pulmonary disease (COPD).

a. Review of Resident #7's current FL2 dated 03/17/21 revealed there was an order for vitamin B12 1000mcg take one tablet every day.

Review of Resident #7's subsequent physician order summary (POS) signed 05/12/21 revealed there was an order for vitamin B12 1000mcg extended release (ER) tablet, take one daily.

Review of Resident #7's November 2021 eMAR revealed:
-There was a computer generated entry for vitamin B12 1000mcg ER, take once daily at 8:00am.
-Vitamin B12 1000mcg ER was documented as administered daily from 11/01/21 through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 344	Continued From page 21 11/08/21 at 8:00am. Observation during the medication pass on 11/09/21 at 9:40am revealed: -The medication aide (MA) removed Resident #7's medications from the medication cart. -The pharmacy generated label on the vitamin blister pack read vitamin B12 1000mcg take one tablet daily. -The MA compared the blister pack label to the order entry on the eMAR and determined she should clarify the order. -The MA did not administer the medication. Observation of Resident #7's medications available for administration on 11/09/21 at 1:18pm revealed one blister pack of 30 tablets of vitamin B12 1000 mcg, with 26 tablets remaining. Telephone interview with the pharmacist at the facility contracted pharmacy on 11/10/21 at 4:00pm revealed: -The pharmacy had a signed physician's order for Resident #7 dated 07/18/18 for vitamin B12 100mcg one tablet daily. -There was no pharmacy record of the vitamin B12 1000mcg order changing to vitamin B12 1000mcg extended release (ER). -There was no record pharmacy staff had not been contacted by facility staff to clarify Resident #7's vitamin B12 order until 11/09/21. Interview with the first shift MA on 11/09/21 at 10:10am revealed: -In performing safety checks before administering medications, she observed the label on Resident #7's Vitamin B12 1000mcg blister pack did not match the order on the eMAR. -She usually administered medications in the assisted living (AL) community and did not know	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 344	Continued From page 22	D 344		

if the Vitamin B12 order had been clarified prior to this morning.

Attempted telephone interview with the primary care physician (PCP) on 11/10/21 at 3:10pm was unsuccessful.

Refer to interview with Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am.

Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:25am.

Refer to telephone interview with the Executive Director on 11/15/21 at 3:55pm

b. Review of Resident #7's signed physician order dated 10/28/21 revealed:
-There was an order for natamycin eye drops to treat conjunctivitis, one drop in the left eye three times a day for 2 weeks, from 10/28/21 through 11/11/21.
-Natamycin eye drops, one drop in the left eye twice a day, from 11/12/21 to 11/25/21 for 2 weeks.
-Natamycin eye drops, one drop in the left eye once daily from 11/26/21 through 12/09/21 for 2 weeks.

Review of Resident #7's October 2021 eMAR revealed:
-There was a computer generated entry for natamycin eye drops, one drop in the left eye three times daily.
-Natamycin was documented as administered three times a day from 10/28/21 through 10/31/21.

Review of Resident #7's November 2021 eMAR revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 344	Continued From page 23	D 344		

-There was a computer generated entry for natamycin eye drops, one drop in the left eye three times daily.
-Natamycin eye drops were documented as administered three times daily from 11/01/21 through 11/08/21.
-The computer generated entry continued from 11/09/21 through 11/25/21 as natamycin eye drops one drop in the left eye three times daily.
-Natamycin eye drops were documented as administered 21 doses from 11/09/21 through 11/15/21.
-Natamycin eye drops should have been administered 14 doses from 11/09/21 through 11/15/21.

Observation of Resident #7's medications available for administration on 11/09/21 at 1:18pm revealed:
-There was a bottle of natamycin eye drops with a computer generated pharmacy label which read: one drop in the left eye three times a day for 2 weeks, from 10/28/21 through 11/11/21; from 11/12/21 through 11/25/21, natamycin eye drops one drop in the left eye twice a day for 2 weeks; from 11/26/21 through 12/09/21, natamycin eye drops, one drop in the left eye once daily.
-The eye drop bottle was opened and approximately three-quarters of the natamycin remained.

Interview with the first shift SCU MA on 11/09/21 at 10:15am revealed:
-In performing safety checks before administering medications, she observed the label on Resident #7's did not match the order on the eMAR.
-She did not know if the natamycin order had been clarified prior to this morning.

Telephone interview with the facility contracted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 344	Continued From page 24	D 344		

pharmacy on 11/10/21 at 4:00pm revealed:
-The pharmacy had a signed physician's order for Resident #7's dated 10/28/21 for natamycin eye drops.
-The order had 3 components: from 10/21/21 through 11/11/21 natamycin eye drops, one drop in the left eye three times a day; from 11/12/21 through 11/25/21 natamycin eye drops, one drop in the left eye twice a day; and from 11/26/21 through 12/09/21 natamycin eye drops one drop in the left eye once daily for 2 weeks.

Attempted telephone interview with the primary care physician (PCP) on 11/10/21 at 3:10pm was unsuccessful.

Based on observations, interviews and record reviews it was determined Resident #7 was not interviewable.

Refer to interview with health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am.

Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:25am.

Refer to telephone interview with the Executive Director on 11/15/21 at 3:55pm.

2. Review of Resident #6's current FL2 dated 03/17/21 revealed diagnoses included Alzheimer dementia, diverticulitis and diarrhea.

Review of Resident #6's subsequent signed physician order date 11/04/21 revealed an order for benefiber, used to treat gastrointestinal issues, twice daily.

Observation during the SCU medication pass on 11/09/21 at 9:40am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 344	Continued From page 25	D 344		

-The MA removed Resident #6's medications from the medication cart.
-Resident #6's benefiber bottle had a pharmacy generated label that read: Mix one dose with choice of liquid and drink by mouth.
-The fill date was 11/04/21.
-The label covered the manufacturer's directions on the bottle.
-There were no packets of benefiber on the cart.

Review of Resident #6's November 2021 eMAR revealed:
-There was a computer generated entry for benefiber packets for diarrhea, give 1 packet by mouth 2 times a day, to be administered at 8:00am and 8:00pm.
-The benefiber packets were documented as administered on 11/05/21 at 8:00am and 8:00pm, 11/07/21 at 8:00pm and 11/08/21 at 8:00pm.
-The benefiber packets were documented as: 'awaiting medication' on 11/04 at 8:00pm; 'medication not available' on 11/06/21 at 8:00am and 8:00pm and 11/07/21 at 8:00am; and 11/08/21 at 8:00am 'medication not on the cart'.

Observation of Resident #6's medications available for administration on 11/09/21 at 1:18pm revealed:
-There was a benefiber bottle with a pharmacy generated label that read: Mix one dose with choice of liquid and drink by mouth.
-The fill date was 11/04/21.
-There were no benefiber packets on the medication cart.

Interview with the first shift MA on 11/09/21 at 10:15am revealed:
-In performing safety checks before administering medications, she observed the label on Resident #6's benefiber bottle did not match the order on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 344	Continued From page 26	D 344		

the eMAR.
-She would not administer the benefiber until the order was clarified with the pharmacy.

Interview with the second shift SCU MA on 11/10/21 at 5:15pm revealed:
-She administered the benefiber powder to Resident #6 on second shift.
-She added one teaspoon of benefiber powder to a drink of the resident's choice-usually water.
-She could not point out any directions of measurement on the label.
-She thought 1 teaspoon was the correct dosage from prior experience.

Telephone interview with the pharmacist at the facility contracted pharmacy on 11/10/21 at 4:00pm revealed:
-The pharmacy had a signed physician's order for Resident #6 dated 11/04/21 for benefiber mix one dose with choice of liquid and drink by mouth.
-The benefiber was sent to the facility on 11/04/21.
-The pharmacy label reflected the physician's order.

Attempted telephone interview with the primary care physician (PCP) on 11/10/21 at 3:10pm was unsuccessful.

Refer to interview with Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am.

Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:25am.

Refer to telephone interview with the Executive Director on 11/15/21 at 3:55pm.

Based on observations, interviews and record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 344	Continued From page 27 reviews it was determined Resident #6 was not interviewable. Interview with Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am revealed: -When the monthly cycle fill medications arrived at the facility, the third shift medication aides (MAs) should compare the directions on each label of the medications to the order on the electronic medication administration record (eMARs). -If the medication label and the order on the eMAR were not the same, they should remove the medication and let the first shift clinical team follow up with the pharmacy. -When the MAs were administering medications, they were trained to compare the label on the medication to the order entered on the eMAR as part of their safety checks. -If the medication label did not match the order on the eMAR, the MA should clarify the order with the pharmacy and if necessary with the prescribing physician. -The MAs should not administer a medication whose label did not match the order entered on the eMAR. Interview with the District Director of Clinical Services on 11/10/21 at 11:25am revealed: -It was the responsibility of each MA who passed medications to the residents to compare the label on the medication with the order entered on the eMAR. -If the medication label and the order entry were not the same, the MA should contact the pharmacy for clarification. -The MA could place a handwritten "direction change" on the medication label until the pharmacy sent over a new blister pack with the corrected label.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 344	Continued From page 28 -Any MA passing medications should have been aware of the discrepancy between the medication labels and the orders and clarified the orders themselves. Telephone interview with the Executive Director on 11/15/21 at 3:55pm revealed: -She expected the MAs to compare the label on the medication with the order entered on the eMAR to ensure they were the same. -If the medication directions on the label were different from the order entered, it was the responsibility of the MA to clarify the order. -The MA should call the pharmacy and if necessary contact the physician. -The pharmacy should send a new blister pack with the corrected label as soon as the order was clarified. -The MA could correct the order on the eMAR if it was entered incorrectly.	D 344		
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 ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 4 residents	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 29	D 358		

(Resident #6) observed on the medication pass related to a probiotic supplement used to restore healthy gut flora that was not available to administer, and 2 of 5 sampled residents (Residents #3 and #4) related to a medication for dementia (Resident #3) and a vitamin supplement for low levels of vitamin D (Resident #4).

The findings are:

1. The medication error rate was 3% as evidenced by the observation of 1 error out of 32 opportunities on 11/09/21 during the 9:00am to 10:00am medication pass.

A request was made for the facility's Medication Administration policy and was not provided prior to survey exit on 11/15/21.

Review of Resident #6's current FL2 dated 10/13/21 revealed diagnoses included Alzheimer dementia, diverticulitis and diarrhea.

Review of Resident #6's record revealed a signed physician's order dated 11/04/21 for florastor, a probiotic to support healthy digestion, 500mg twice a day.

Review of Resident #6's progress notes dated 11/02/21 revealed Resident #6 had a gastrology appointment on 11/04/21 for diarrhea and blood in her stool.

Review of Resident #6's November 2021 electronic medication administration record (eMAR) revealed:
-There was a computer-generated entry for florastor 250mg, take 2 capsules twice daily to be administered at 8:00am and 8:00pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 30	D 358		

-Florastor was documented as administered on 11/05/21 at 8:00am and 11/06/21 8:00am.
-Florastor was not administered on 11/04 8:00pm, 11/05 8:00pm, 11/06 8:00pm, 11/07 8:00am and 8:00pm, and 11/09/21 at 8:00am with reason "see nurses notes".
-No additional notes were provided before survey exit.

Review of Resident #6's progress notes dated 11/02/21 revealed:
-Resident #6 had a gastrology appointment on 11/04/21 for diarrhea and blood in her stool.
-Progress notes dated 11/04/21 do not document the new prescription for florastor 250mg two tablets twice a day.
-Progress notes dated 11/04/21 through 11/10/21 do not document Florastor as not available for administration nor any contact with the pharmacy regarding the delivery of the probiotic supplement.

Observation of the 9:00am medication pass on 11/09/21 at 9:40am revealed Resident #6's florastor 250mg take 2 tablets at 8:00am was not available for administration.

Interview with the medication aide (MA) on 11/09/21 at 10:10am revealed:
-She did not know why the florastor was not available to administer to Resident #6.
-The facility policy was to follow up with the pharmacy if a medication did not arrive in the facility within 24 hours of the order.

Telephone interview with a technician from the facility's contracted pharmacy on 11/10/21 at 4:00pm revealed:
-The facility received their monthly cycle fill medications on 11/05/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 31	D 358		

-The pharmacy had a signed physician's order for Resident #6 dated 11/04/21 for florastor 500mg twice daily was sent to the pharmacy on 11/04/21.
-Four tablets were sent to the facility on 11/04/21.
-The facility did not request any additional tablets until 11/09/21.
-On 11/09/21, 60 tablets in 2 blister packs were sent to the facility for Resident#5's florastor 250mg twice daily, when the facility requested a refill..

Telephone interview with the Registered Nurse (RN) at Resident #6's primary care physician (PCP)'s office on 11/10/21 at 4:45pm revealed:
-Resident #6 has had several bouts of unresolved diarrhea and blood in her stool.
-The resident was prescribed the florastor 500mg twice a day by the gastro-enterologist to treat these issues.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

Refer to interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am.

Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:25am.

Refer to telephone interview with the Executive Director (ED) on 11/15/21 at 3:55pm.

2. Review of Resident #3's current FL2 dated 05/17/21 revealed diagnoses included vascular dementia with behavioral disturbances and hypertensive encephalopathy.

Review of Resident #3's record revealed a signed physician's order dated 10/25/21 as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 32	D 358		

-Namenda HCL 5mg, take one tablet every evening for 7 days at bedtime (10/26/21 to 11/01/21).
-Namenda HCL 5mg, take one tablet in the morning and one tablet at bedtime for 7 days (11/02/21 to 11/08/21).
-Namenda HCL 5mg, take one tablet in the morning and 10mg tablet at bedtime for 7 days (11/09 to 11/16/21).
-Namenda HCL 10 mg twice a day to start on 11/17/21.

Review of Resident #3's October 2021 and November 2021 electronic medication administration records (eMARs) revealed
-There was a computer-generated entry for namenda 5mg, take 1 table at bedtime for one week to equal 10mg twice daily when titration was complete.
-Namenda 5mg was documented as administered at 8:00pm from 10/26/21 to 10/31/21.

Review of Resident #3's November 2021 eMAR from 11/02/21 through 11/10/21 revealed:
-There was a computer-generated entry for namenda 5mg, take 1 tablet twice daily for one week to equal 10mg twice daily when titration was complete.
-Namenda 5mg was documented as administered from 11/02/21 at 8:00pm through 11/08/21 twice daily and 11/09/21 at 8:00am.
-There was no entry for namenda 5mg, take 1 tablet in the morning and 10mg tablet at bedtime for 7 days (11/09 through 11/16/21).
-There was no documentation namenda 5mg was administered on 11/09/21 at 8:00am.

Observation of Resident #3's medications on hand on 11/10/21 at 1:40pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 33	D 358		

-There was one blister pack labeled namenda 5mg take one tablet twice a day for 7 days, with 8 tablets remaining.
-There was a handwritten note on the blister pack "Start on 11/02/21".
-There was a second blister pack labeled namenda 10mg take one tablet twice daily with 23 tablets remaining dispensed on 11/05/21.

Interview with the medication aide (MA) on 11/10/21 at revealed:
-She had administered Resident #3's Namenda on 11/09/21.
-She had administered Namenda 5mg during the morning medication pass.
-She did not know who had been administering Namenda 10mg on 5 separate occasions.
-Resident #3 should be administered Namenda 5mg in the morning and the evening until 11/09/21.
-On 11/09/21, Resident #3 should be administered Namenda 5mg in the morning and 10mg in the evening.
-Having the 10mg blister pack on the medication cart before it was time to start that dose was confusing.

Telephone interview with the facility contracted pharmacist on 11/10/21 at 4:00pm revealed:
-On 10/25/21 Resident #3's neurologist sent the following Namenda order to be administered in the following dosages:
-Namenda HCL 5mg, take one tablet every evening for 7 days at bedtime (10/26/21 through 11/01/21).
-Namenda HCL 5mg, take one tablet in the morning and one tablet at bedtime for 7 days (11/02/21 through 11/08/21).
-Namenda HCL 5mg, take one tablet in the morning and 10mg tablet at bedtime for 7 days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 34	D 358		

(11/09 through 11/16/21).
-Namenda HCL 10 mg twice a day to start on 11/17/21.
-On 10/25/21, 42 tablets of namenda 5mg was sent to the facility.
-On 11/05, 56 tablets of namenda 10mg was sent to the facility.
-If the dosage for namenda was not followed as prescribed, over time Resident #3 could experience lapses in memory.

Telephone interview with the Registered Nurse (RN) at Resident #3's neurologist's office on 11/15/21 at 2:05pm revealed:
-On 10/25/21 Resident #3's neurologist ordered namenda to be administered in the following dosages:
-Namenda HCL 5mg, take one tablet every evening for 7 days at bedtime (10/26/21 through 11/01/21).
-Namenda HCL 5mg, take one tablet in the morning and one tablet at bedtime for 7 days (11/02/21 through 11/08/21).
-Namenda HCL 5mg, take one tablet in the morning and 10mg tablet at bedtime for 7 days (11/09 through 11/16/21).
-Namenda HCL 10 mg twice a day to start on 11/17/21.
-The resident should be administered namenda 10mg twice a day by week 4 (11/17/21).
-The dosage was prescribed for the optimal benefit of memory enhancement.

Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.

Refer to interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 35	D 358		

Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:25am.

Refer to telephone interview with the Executive Director (ED) on 11/15/21 at 3:55pm.

3. Review of Resident #1's current FL2 dated 10/13/21 revealed:
-Diagnoses included diabetes mellitus type I, gastritis and hypertension.
-There was an order Tramadol (a pain medication) 50mg daily as needed for pain.

Review of Resident #1's primary care provider's (PCP) order dated 10/28/21 revealed:
-He was to receive Tramadol 50mg daily.
-The order was annotated as faxed on 10/28/21.

Review of Resident #1's October 2021 and November 2021 electronic medication administration records (eMARs) revealed:
-There was an entry for Tramadol 50mg daily as needed for pain.
-The Tramadol 50mg as needed was documented as administered three instances in October 2021 on 10/08/21, 10/10/21, and 10/15/21.
-There was no documentation Tramadol was administered in November 2021.
-There was no entry for Tramadol 50mg daily.

Observation of medications on hand for Resident #1 on 11/10/21 at 12:02pm revealed there was no Tramadol available to administer to Resident #1.

Interview with the medication aide (MA) on 11/10/21 at 12:02pm revealed:
-She did not recall any time Resident #1 complained of pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 36 -She was not aware Resident #1 had an order for Tramadol. -The Health and Wellness Coordinator (HWC) or the MA was responsible to fax new orders to the pharmacy and enter the medication on the resident's eMAR. Telephone interview with a pharmacist with the facility's contracted pharmacy on 11/10/21 at 2:13pm revealed: -The pharmacy received the order for Tramadol 50mg daily for Resident #1 on 10/28/21. -The pharmacy profiled Resident #1's medications only because he received them from a different pharmacy. -The facility had not contacted them as to why the medication was not dispensed. Interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 2:43pm revealed: -She or a MA were responsible for faxing new orders to the pharmacy and to place the order on the resident's eMAR. -She faxed Resident #1's Tramadol order to the pharmacy on 10/28/21. -She did not notice it was changed to routine and did not change it on Resident #1's eMAR. -The MAs would not know Resident #1's Tramadol was to be given routine because she had not changed the order in the eMAR. -She did not know why Tramadol was not available for Resident #1 on the medication cart. -Resident #1 received most of his medications from an outside pharmacy but the facility contracted pharmacy could fill his prescriptions if the order was faxed to them. -She did not know why the pharmacy had not sent the Tramadol 50mg that was to be administered daily to Resident #1.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 37	D 358		

Interview with Resident #1 on 11/10/21 at 5:28pm revealed:
-He did not experience pain very often.
-His shoulder ached occasionally but not bad enough to ask for pain medication.

Telephone interview with Resident #1's PCP on 11/10/21 at 5:25pm revealed:
-Resident #1 frequently complained of shoulder pain.
-She prescribed Tramadol 50mg daily for Resident #1 because facility staff told her Resident #1 was requesting the Tramadol daily.
-She expected medications to be administered as ordered.

Telephone interview with the Executive Director (ED) on 11/15/21 at 3:55pm revealed:
-The HWC and the MAs were responsible for faxing new medication orders to the pharmacy and entering orders on the eMARS in the absence of the HWD.
-She was not aware Resident #1 was not receiving the Tramadol as ordered.

Refer to interview with the Health and Wellness Coordinator on 11/10/21 at 9:58am.

Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:25am.

Refer to telephone interview with the Executive Director (ED) on 11/15/21 at 3:55pm.

4. Review of Resident #4's current FL2 dated 10/11/21 revealed:
-Diagnoses included lumbar neuritis, frequent falls and gait instability.
-There was an order for vitamin D 2000 units, two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 38	D 358		

capsules daily.

Review of Resident #4's resident register revealed she was admitted to the facility on 10/18/21.

Review of Resident #4's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for vitamin D, two capsules daily at 8:00am.
-There was no dosage for the vitamin D.
-Vitamin D was documented as administered at 8:00am from 10/21/21 to 10/31/21.

Review of Resident #4's November 2021 eMARs revealed:
-There was an entry for vitamin D, two capsules daily at 8:00am.
-There was no dosage for the vitamin D.
-Vitamin D was documented as administered at 8:00pm from 11/01/21 to 11/09/21.

Observation of Resident #4's medications on hand on 11/10/21 at 12:02pm revealed:
-There was a bottle of over-the-counter vitamin D3 1000 unit capsules.
-There were no administration instructions for Resident #4 listed on the bottle.

Interview with the medication aide (MA) on 11/10/21 at 12:02pm revealed:
-She had administered vitamin D to Resident #4 that morning.
-She administered two capsules of the vitamin D 1000 unit capsules.
-She was trained to compare the eMAR entry with the medication before administration.
-There was no dosage listed for the vitamin D entry on the eMAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 39 -She did not know why she had not caught that the dosage was not identified on Resident #4's eMAR. -The MAs or the Health and Wellness Coordinator (HWC) were responsible for ensuring medications were labeled and matched the physician's order on the eMAR. Interview with Resident #4 on 11/09/21 at 9:38am revealed: -The medication aide (MA) brought her medications to her. -She thought they brought the medications that were prescribed for her. Attempted telephone interview with Resident #4's PCP on 11/10/21 at 1:57pm was unsuccessful. Refer to interview with the Health and Wellness Coordinator on 11/10/21 at 9:58am. Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:25am. Refer to telephone interview with the Executive Director (ED) on 11/15/21 at 3:55pm. _____ Interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am revealed: -The medication aides (MAs), the Health and Wellness Director (HWD) or myself could enter physician's medication orders and treatments on the residents' electronic medication administration (eMAR). -If the MAs enter the order, there was a Tracking Order form that should be completed. -The MAs were responsible for faxing new orders to the pharmacy and ensuring the new medication arrived in the facility.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 40	D 358		

-When the MAs were administering medications, they were trained to compare the label on the medication to the order entered on the eMAR as part of their safety checks.
-If the medication label did not match the order on the eMAR, the MA should clarify the order with the pharmacy and if necessary with the prescribing physician.
-The MAs should not administer a medication whose label did not match the order entered on the eMAR.
-She did not perform medication cart audits.
-The pharmacy audited the medication carts monthly.

Interview with the District Director of Clinical Services on 11/10/21 at 11:25am revealed:
-The previous HWD entered all new orders onto the resident's electronic medication administration record (eMAR).
-There was a new Tracking Order process the medication aides (MAs) completed and submitted to the nursing staff.
-The MAs should fax a new order to the pharmacy and transcribe the order to the resident's eMAR.
-The HWC or the HWD verified the accuracy of the eMAR entry.
-When the medication was received in the facility, the MA dated and initialed the Tracking form.
-If the medication did not arrive in the facility by the next evening, the MA should follow up with the pharmacy.
-Medications should be in the facility within 24 hours or less.
-MAs should compare the medication labels to the eMAR entries to ensure accuracy, before administering medications to the residents.
-It was the responsibility of the MAs to contact the pharmacy if the medication was not in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 41 community or if the label did not match the eMAR entry. Telephone interview with the Executive Director (ED) on 11/15/21 at 3:55pm revealed: -She did not think there was any "second check" for accuracy of orders when the nursing staff entered an order onto the eMARs. -She did not review the eMARs for accuracy. -She expected the MAs to ensure medications administered to the residents were accurate according to the physician's order. -It was the responsibility of the MAs to ensure the medications on the resident's profile were in the facility and available for administration. -The MAs should contact the pharmacy if a medication was not in the community or the medication was not the correct dosage.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 367	Continued From page 42	D 367		

(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure medication administration records were complete and accurate for 4 of 5 residents sampled including medications for a respiratory infection (Resident #5), a medication to slow the cognitive decline due to dementia (Resident #3) and vitamin supplements (Resident's #2 and #4) and 2 of 4 residents sampled in the medication pass related to eye drops for a fungal infection and a vitamin supplement (Resident #7), and a fiber powder for gastric discomfort (Resident #6).

The findings are:

1.Review of Resident #5's current FL2 dated 03/11/21 revealed diagnoses included atrial fibrillation, coronary artery disease and hyperlipidemia.

Review of Resident #5's physician's order dated 08/04/21 revealed methylprednisolone 4mg tablets in a dose pack, take as directed on the pack.

Review of Resident #5's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for methylprednisolone 4 mg tablet scheduled for 8:00am and to follow directions on package for amount and frequency.
-Methylprednisolone 4 mg was documented as administered on 08/07/21, 08/20/21, 08/21/21,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 367	Continued From page 43	D 367		

08/22/21, 08/29/21, 08/30/21 and 08/31/21.
-Under methylprednisolone 4 mg other/see nurse's notes was documented on 08/05/21, 08/06/21, 08/09/21-08/11/21, 08/16/21, 08/24/21 and 08/26/21-08/28/21.
-Under methylprednisolone 4 mg hold/see nurse's notes was documented on 08/12/21-08/15/21, 08/18/21 and 08/19/21.
-Under methylprednisolone 4 mg pharmacy action required was documented on 08/08/21, 08/17/21, 08/23/21 and 08/25/21.
-There was documentation that methylprednisolone 4 mg will be discontinued on 09/20/21.

Review of Resident #5's September eMAR revealed:
-There was an entry for methylprednisolone 4 mg tablet scheduled for 8:00am and to follow directions on package for amount and frequency.
-Methylprednisolone 4mg was documented as administered on 09/03/21, 09/07/21, 09/10/21, 09/12/21 and 09/17/21.
-Under methylprednisolone 4 mg other/see nurse's note was documented on 09/01/21, 09/02/21, 09/06/21 and 09/13/21- 09/16/21.
-Under methylprednisolone 4 mg hold/see nurse's note was documented 09/08/21, 09/09/21, and 09/11/21.
-Under methylprednisolone 4 mg pharmacy action required was documented on 09/03/21, /09/04/21 and 09/20/21.
-Under methylprednisolone 4 mg away from home with meds was documented on 09/18/21 and 09/19/21.
-There was documentation that methylprednisolone 4 mg was discontinued on 09/20/21.

Review of Resident #5's progress notes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 367	Continued From page 44	D 367		

generated from the eMAR revealed:
-Entry on 09/13/21 stated methylprednisolone had been discontinued.
-Entry on 09/14/21 stated methylprednisolone was finished.
-Entry on 09/20/21 stated methylprednisolone was not available, will contact pharmacy.

Interview with a medication aide (MA) on 11/10/21 at 1:00pm revealed:
-Resident #5 might have been on a prednisone pack in August 2021 but she was not trained on the medication cart at that time.
-The previous Health and Wellness Director (HWD) was the only staff member that was able to edit the eMAR.
-If an order needed to be changed on the eMAR she notified the previous HWD.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/10/21 at 9:29am revealed:
-The facility was responsible for putting orders on the eMAR.
-21 tablets of methylprednisolone 4 mg was dispensed on 08/04/21.
-Methylprednisolone 4 mg should have been administered over a 6 day period.
-The administration instructions were printed on the package and faxed to the facility.
-The administration instructions on the package for day 1 were: 2 tablets at breakfast, 1 tablet at lunch, 1 tablet at supper and 2 tablets at bedtime.
-The administration instructions on the package for day 2 were: 1 tablet at breakfast, 1 tablet at lunch, 1 tablet at supper and 2 tablets at bedtime.
-The administration instructions on the package for day 3 were: 1 tablet at breakfast, 1 tablet at lunch, 1 tablet at supper and 1 tablet at bedtime.
-The administration instructions on the package

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 367	Continued From page 45	D 367		

for day 4 were: 1 tablet at breakfast, 1 tablet at lunch, do not give a tablet at supper and 1 tablet at bedtime.
-The administration instructions on the package for day 5 were: 1 tablet at breakfast, do not give a tablet at lunch, do not give a tablet at supper and 1 tablet at bedtime.
-The administration instructions on the package for day 6 were: only give 1 tablet at breakfast.

Telephone interview with Resident #5's Registered Nurse (RN) at the primary care physician's (PCP) office on 11/10/21 at 3:31pm revealed:
-Resident #5 was not administered the medication as ordered.
-She would have experienced a longer recovery period from her respiratory virus then if the medication was administered as ordered.

Refer to the interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am.

Refer to the interview with the District Director of Clinical Services (DDSC) on 11/10/21 at 11:25am.

Refer to the telephone interview with the Executive Director on 11/15/21 at 3:55pm.

The Health and Wellness Director (HWD) was not available to interview.

2. Review of Resident #2's current FL2 dated 05/28/21 revealed:
-Diagnoses included vascular dementia, high blood pressure, cardiovascular disease, macular degeneration and chronic insomnia.
-An order for vitamin C 500 mg daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 367	Continued From page 46 Observation of Resident #2's medications on hand on 11/10/21 revealed: -A package of 500 mg vitamin C tablets. -Administration instructions to take 1 tablet daily. Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin C scheduled at 8:00am. -There was no dosage documented for vitamin C. -Vitamin C was documented as administered daily 09/01/21-09/30/21. Review of Resident #2's October 2021 eMAR revealed: -There was an entry for vitamin C scheduled at 8:00am. -There was no dosage documented for vitamin C. -Vitamin C was documented as administered daily 010/01/21-10/31/21. Review of Resident #2's November 2021 eMAR revealed: -There was an entry for vitamin C scheduled at 8:00am. -Vitamin C was documented as administered daily 11/01/21-11/09/21. Interview with a medication aide (MA) on 11/10/21 at 12:02pm revealed: -The order should have been clarified since no dosage was identified on the eMAR. -The MAs or the Health and Wellness Coordinator (HWC) were responsible for verifying orders on the eMAR. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/10/21 at 9:29am revealed the facility entered medications	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 367	Continued From page 47	D 367		

on to their eMAR.

Refer to interview with the HWC on 11/10/21 at 9:58am.

Refer to interview with the District Director of Clinical Services (DDCS) on 11/10/21 at 11:25am

Refer to telephone interview with the Executive Director on 11/15/21 at 3:55pm.

The Health and Wellness Director (HWD) was not available to interview.

Based on interviews, observations and record review Resident #2 was uninterviewable.

3. Review of Resident #7's current FL2 dated 03/17/21 revealed diagnoses included a major depressive disorder, hypertension, transient ischemic attack (TIA) and chronic obstructive pulmonary disease (COPD).

Review of Resident #7's current FL2 dated 03/17/21 revealed there was an order for Vitamin B12 1000mcg take one tablet every day.

Review of Resident #7's subsequent physician order summary (POS) signed 05/12/21 revealed there was an order for Vitamin B12 1000mcg extended release (ER) tablet, take one daily.

Review of Resident #7's September 2021, October 2021 and November 2021 electronic medication administration records (eMARs) from 09/01/21 through 11/08/21 revealed:
-There was a computer generated entry for Vitamin B12 tablet 1000mcg ER take once daily at 8:00am.
-Vitamin B12 1000mcg ER was documented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 367	Continued From page 48	D 367		

administered daily from 09/01/21/through 11/08/21 at 8:00am.

Observation during the medication pass on 11/09/21 at 9:40am revealed the pharmacy generated label on Resident #7's Vitamin B12 blister pack read Vitamin B12 1000mcg take one tablet daily.

Observation of Resident #7's medications available for administration on 11/09/21 at 1:18pm revealed one blister pack of 30 tablets of Vitamin B12 1000mcg take one tablet daily, with 26 tablets remaining.

Telephone interview with the facility's contracted pharmacist on 11/10/21 at 4:00pm revealed:
-Vitamin B12 100mcg, take one tablet daily, was on Resident #7's medication profile since 07/18/2018.
-There was no pharmacy record of the Vitamin B12 1000mcg order changing to the extended release tablet.
-The pharmacy did not enter Resident #7's vitamin B12 on to the eMAR.

Interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 3:03pm revealed:
-The MAs and the nurses could put an order onto the eMAR.
-If the MA entered an order onto the eMAR they were responsible for completing a tracking form and submitting the form to her or the Health and Wellness Director (HWD).
-She or the HWD would review the order that had been entered for accuracy.
-She did not know Resident #7's order for Vitamin B12 1000mcg had changed on 05/12/21 to an extended release tablet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 367	Continued From page 49	D 367		

-At that time, the HWD was the only staff entering resident's orders on the eMAR.
-There was no oversite of orders when entered by the nursing staff.

Interview with the Executive Director on 11/15/21 at 3:55pm revealed:
-The HWD was the only staff entering orders on the eMAR until 2-3 weeks ago..
-The HWD had entered the order on the eMAR to change Resident #7's Vitamin B12 1000mcg to an extended release tablet.
-She should have faxed the order to the pharmacy for the technicians to enter the Vitamin B12 1000mcg extended release tablet once daily into Resident #7's medication profile.
-She did not know why the pharmacy never received the new order on 05/12/21 changing Resident #7's vitamin B12 to an extended release tablet.

Attempted interview with the previous Health and Wellness Director (HWD) was unsuccessful.

Attempted telephone interview with the primary care physician (PCP) on 11/10/21 at 3:10pm was unsuccessful.

Based on observations, interviews and record reviews it was determined Resident #7 was not interviewable.

Refer to interview with Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am.

Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:25am.

Refer to telephone interview with the Executive Director on 11/15/21 at 3:55pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 367	Continued From page 50 4. Review of Resident #3's current FL2 dated 05/17/21 revealed diagnoses included vascular dementia with behavioral disturbances and hypertensive encephalopathy. Review of Resident #3's record revealed a signed physician's order dated 10/25/21 as follows: -Namenda HCL 5mg, take one tablet every evening for 7 days at bedtime (10/26/21 through 11/01/21). -Namenda HCL 5mg, take one tablet in the morning and one tablet at bedtime for 7 days (11/02/21 through 11/08/21). -Namenda HCL 5mg, take one tablet in the morning and 10mg tablet at bedtime for 7 days (11/09 through 11/16/21). -Namenda HCL 10 mg twice a day to start on 11/17/21. Review of Resident #3's November 2021 eMAR from 11/09/21 through 11/17/21 revealed: -There was a computer-generated entry for namenda 5mg, take 1 tablet twice daily for one week to equal 10mg twice daily when titration was complete. -There was no eMAR entry for namenda 5mg, take 1 tablet in the morning and 10mg tablet at bedtime for 7 days (11/09 through 11/16/21). Telephone interview with the Registered nurse (RN) at Resident #3's neurologist's office on 11/15/21 at 2:05pm revealed: -The resident should be administered namenda 10mg twice a day by week four (11/17/21). -She expected the facility to administer the namenda dosage as the physician ordered. -The dosage has been prescribed for the optimal benefit of memory enhancement.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 367	Continued From page 51	D 367		

Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.

Refer to interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am.

Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:25am.

Refer to telephone interview with the Executive Director (ED) on 11/15/21 at 3:55pm.

5. Review of Resident #4's current FL2 dated 10/11/21 revealed:
-Diagnoses included lumbar neuritis, frequent falls, and unsteady gait.
-There was an order for vitamin D 2000 units, two capsules daily.

Review of Resident #4's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for vitamin D, two capsules daily scheduled at 8:00am.
-There was no dosage identified on the eMAR.
-Vitamin D was documented as administered daily 10/21/21 to 10/31/21.

Review of Resident #4's November 2021 eMAR revealed:
-There was an entry for vitamin D, two capsules daily scheduled at 8:00am.
-There was no dosage identified on the eMAR.
-Vitamin D was documented as administered daily 11/01/21 to 11/09/21.

Observation of Resident #4's medications on hand on 11/10/21 at 12:02pm revealed:
-A bottle of over the counter vitamin D 1000 unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 367	Continued From page 52 capsules. -There were no administration instructions for Resident #4 listed on the bottle. Interview with a medication aide (MA) on 11/10/21 at 12:02pm revealed: -There was no dosage for Resident #4's vitamin D listed on her eMAR. -She administered two capsules of the vitamin D 1000 units to Resident #4 that morning. -The order should have been clarified since no dosage was identified on the eMAR. -She did not know why she had not caught that the dosage was not identified on the eMAR. -The MAs or the Health and Wellness Coordinator (HWC) were responsible to clarify orders when necessary. Refer to interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am. Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:25am. Refer to telephone interview with the Executive Director (ED) on 11/15/21 at 3:55pm. _____ Interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am revealed: -The medication aides (MAs), the Health and Wellness Director or myself could enter physician's medication orders and treatments on the residents' electronic medication administration (eMAR). -If the MAs enter the order, there was a tracking order form that should be completed. -The tracking order form was submitted to the HWC or HWD and they would review the order for accuracy.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 367	Continued From page 53 -If the HWC or HWD entered the order, there was no second review of the entry. -The HWD was entering all orders on the eMAR until she left two weeks ago. -She did not review the eMARS. Interview with the District Director of Clinical Services on 11/10/21 at 11:25am revealed: -There was a new tracking order form the community recently implemented. -The MAs complete this form when a new order was received and entered on the eMAR. -The form was then submitted to the HWC until the newly hired HWD finished her training. -The HWC and HWD reviewed the tracking form to ensure the MAs have completed all the steps of a new order: faxing the pharmacy, entering the order on the eMAR, documenting the new order in the progress notes and the delivery of the medication. -Presently there was no oversite for orders entered accurately on the eMAR by the nursing staff, the HWC or HWD. Telephone interview with the Executive Director (ED) on 11/15/21 at 3:55pm revealed: -A new tracking order form was initiated approximately 2 weeks ago to allow MAs to enter new orders onto the eMAR. -Previously, the HWD was the only staff who entered orders onto the eMAR. -She did not think there was any oversite to check for accuracy of orders when the nursing staff entered an order onto the eMARS. -She did not review the eMARS for accuracy. -She was surprised the pharmacy staff who conduct monthly cart audits did not observe any inaccuracy of the eMARs.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 459	Continued From page 54	D 459		
D 459	10A NCAC 13F .1302 Special Care Unit Disclosure 10A NCAC 13F .1302 Special Care Unit Disclosure (a) Only those facilities with units that meet the requirements of this Section may advertise, market or otherwise promote themselves as providing special care units for persons with Alzheimer's Disease or related disorders. (b) The facility shall disclose information about the special care unit according to G.S. 131D-8 and which addresses policies and procedures listed in Rule .1305 of this Section This Rule is not met as evidenced by: The facility failed to disclose the form of care or treatment provided for residents in the special care unit (SCU), which addresses policies and procedures in writing and is presented to each person seeking placement within a SCU or their authorized representative, for 2 of 2 residents (#2 and #3) prior to admission to the SCU. The findings are: 1. Review of Resident #3's FL2 dated 05/17/21 revealed: -Diagnoses included vascular dementia with behavioral disturbances, hypertensive encephalopathy and chronic heart failure. -The resident was intermittently disoriented and exhibited wandering behaviors. -The documented level of care was the SCU. Review of Resident #3's Resident Register revealed he was admitted to the SCU on 05/20/21.	D 459		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 459	Continued From page 55 Review of Resident #3's record revealed there was not a signed and dated SCU Disclosure document in the resident's record. Telephone interview with Resident #3's power of attorney (POA) on 11/09/21 at 2:49pm revealed: -He did not specifically remember signing a Disclosure document on the day of his family member's admission to the SCU. -There were a lot of papers to sign and he could not remember them all. A request was made for documentation of Resident #3's signed SCU Disclosure document and was not provided prior to the survey exit. Refer to interview with Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am. Refer to interview with the District Director of Clinical Services (DDSC) on 11/10/21 at 11:25am. Refer to Interview with Sales Manager on 11/15/21 at at 3:34pm. Refer to telephone interview with the Executive Director on 11/15/21 at 3:55pm. Based on observations, interviews and record review it was determined Resident #3 was not interviewable. 2. Review of Resident #2's current FL2 dated 05/28/21 revealed: -Diagnoses included vascular dementia, high blood pressure, cardiovascular disease, macular degeneration and chronic insomnia. -Recommended level of care was the Special	D 459		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 459	Continued From page 56	D 459		

Care Unit (SCU).

Review of Resident #2's resident register revealed he was admitted to the SCU on 06/08/21.

Review of Resident #2's record on 11/10/21 revealed there was not a SCU Disclosure.

Refer to interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am.

Refer to interview with District Director of Clinical Services (DDSC) on 11/10/21 at 11:25am.

Refer to interview with the Sales Manager on 11/10/21 at 3:34pm.

Refer to telephone interview with Executive Director on 11/15/21 at 3:55pm.

Attempted telephone interview with Resident #2's Power of Attorney (POA) on 11/09/21 at 2:01pm was unsuccessful.

Based interviews, observations and record review Resident #2 was not interviewable.

_____

Interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:58am revealed:
-She was not responsible for ensuring the special care unit (SCU) Disclosure document was signed for residents prior to their admission.
-Disclosure documents were not kept in the resident's health care record.

Interview with the District Director of Clinical Services on 11/10/21 at 11:25am revealed:
-The SCU Disclosure document would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 459	Continued From page 57	D 459		

presented to the responsible party, usually a family member, to review before admission.
-The document was signed and dated and the responsible party had time to ask questions or present specific concerns for their loved one.
-The Executive Director usually presented the Disclosure document and once signed, it was kept in the Business Office Manager (BOM)'s office in the resident's business file.
-All residents being admitted to the SCU had to have a disclosure document signed before admission.
-She did not know 2 of 2 sampled residents did not have disclosure statements in their files.

Interview with the Sales Manager on 11/10/21 at 3:34pm revealed:
- He did not present the Disclosure documents to the responsible party of a resident being admitted to the SCU.
-He thought the ED or Business Office Manager presented the Disclosure at the signing of the admission agreement.

Telephone interview with the Executive Director on 11/15/21 at 3:55pm revealed:
-The Health and Wellness Director was responsible for meeting with the responsible party prior to admission to the SCU and presented them with the Disclosure document.
-The responsible party signed and dated the Disclosure document and it was retained in the resident's file in the business manager's office.
-The Business Office Manager (BOM) confirmed the facility had all the required move in documentation for the new resident.
-She did not know if the BOM audited the residents' files or how often.
-She did not know 2 of 2 sampled residents in the SCU did not have signed Disclosure documents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 2 of 2 sampled residents, (Residents #2, and #3), residing in the Special Care Unit (SCU) had a care plan completed within 30 days of admission to the SCU and signed by a physician. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed with a special care unit (SCU) with a capacity of 19	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 464	Continued From page 59	D 464		

beds.

1.Review of Resident #2's current FL2 dated 05/28/21 revealed:
-Diagnoses included vascular dementia, cardiovascular disease, chronic insomnia, macular degeneration and sensorineural hearing loss.
-He was constantly disoriented, semi-ambulatory and continent of bowel and bladder.
-He required total care for bathing, feeding and dressing.
-The recommended level of care was SCU.

Review of Resident #2's Resident Register revealed he was admitted to the SCU on 06/08/21.

Review of Resident #2's current Care Plan dated 06/10/21 revealed:
-The Care Plan was not signed by the employee that evaluated Resident #2 or by a physician.
-He required assistance with identification and location of food on his plate due to a history of macular degeneration.
-He required physical assistance with the selection of clothes and sometimes required physical assistance dressing himself.
-He sometimes required physical assistance with grooming and bathing himself.
-He required physical assistance with toileting.
-He required stand by assistance when he used his walker and had fallen in the last 12 months.

Observation of Resident #2 on 11/09/21 at 9:40am and 12:00pm revealed:
-During the morning medication pass, the resident was found in his room, sitting in his recliner with the television on.
-He had a stained shirt and a blanket over his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 464	Continued From page 60	D 464		

legs, a brief and no pants or shoes.
-The medication aide (MA) repositioned the call bell for easier accessibility and encouraged the resident not to ambulate on his own, but ring for assistance.
-There was a hospital tray next to his chair with a plate from breakfast.
-There was a walker across the room next to the closet.
-At noontime, his meal was brought to his room and the resident was sitting in his recliner.
-He had the same shirt on since the morning and no pants or shoes.
-The staff set up his meal on the hospital tray next to the recliner.
-The door was closed after delivering his meal.

Interview with a personal care aide (PCA) on 11/09/21 at 10:10am revealed:
-She started her position as PCA and medication aide in training one week ago.
-She did not know the care needs of the residents yet-she was just learning.
-The staff would let her know what tasks to perform for the residents' she was caring for.
-She was not aware of a binder that documented the care needs of the residents.

Interview with a MA on 11/10/21 at 1:15pm revealed:
-There was a care binder at the care station that had a task list for the staff documenting the care needs of each resident on each shift.
-The care staff were to familiarize themselves with the care needs of each resident on their shift.
-The care needs for most of the residents have not changed very much, so only the new staff or agency staff refer to the binder.
-The MA on each shift should be showing any new staff where the binder was located and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 464	Continued From page 61	D 464		

encouraging them to read it before giving care to the residents.
-Resident #2 does not like to take showers or allow the staff to assist him in dressing.
-He does not like to get dressed and prefers to sit in his recliner in a brief and shirt.
-He wants to eat all his meals in his room.
-Staff encourage him to use the call bell when he wants to transfer or ambulate because he was unsteady on his feet.
-We do not place the walker near the recliner or bed because he needs assistance with ambulation.

Review of the Care Binder in the special care unit (SCU) revealed:
-Resident #2 needed staff assistance with dressing and grooming, as well as toileting.
-He required hands on assistance with showers on Monday and Friday.
-He required staff to escort him to the dining room for meals.

Interview with the HWC on 11/10/21 at 2:26pm revealed:
-Resident #2's responsible family member would like to transfer him to the assisted living community.
-The family member believed he would "do better" cognitively in that environment.
-The clinical team at the facility planned on assessing the resident per the daughters wishes.
-She was not sure when the assessment would be performed.

Attempted interview with Resident #2's family member on 11/09/21 at 2:01pm was unsuccessful.

Based on interviews, observations and record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 464	Continued From page 62	D 464		

review Resident #2 was uninterviewable.

Refer to interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:45am.

Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:24am.

Refer to telephone interview with the Executive Director on 11/15/21 at 3:55pm.

2. Review of Resident #3's current FL2 dated 05/17/21 revealed:
-Diagnoses included coronary artery disease (CAD), congestive heart failure (CHF), and vascular dementia with behavior disturbance.
-The resident was intermittently disoriented with wandering behaviors.
-The resident needed personal care assistance with bathing and dressing.
-The resident had an indwelling catheter.
-The resident's recommended level of care was the special care unit (SCU).

Review of Resident #3's Resident Register revealed the resident was admitted to the SCU on 05/16/21 .

Review of Resident #3's record revealed there was no documented care plan completed within 30 days of admission or no documented quarterly resident profile thereafter.

Interview with a SCU personal care aide (PCA) on 11/09/21 at 10:10am revealed:
-She started working on the floor in the SCU a week ago.
-She did not know Resident #3 had an indwelling

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 464	Continued From page 63	D 464		

catheter.
-She did not know how much care he needed in managing the catheter.
-She did not know of a binder that documented the care needs of the residents.

Interview with a SCU medication aide (MA) on 11/10/21 at 1:15pm revealed:
-Resident #3 had an indwelling suprapubic catheter.
-The leg bag was secured to his left leg.
-He would often empty the catheter bag himself or sometimes the PCAs or the MAs would empty it for him.
-She did not remember seeing any written orders for catheter care, but she knew to clean the tubing and the area around the insertion of the tubing, from training at a previous facility.
-She knew to notify the Health and Wellness (HWC) if the urine in the bag was cloudy, brown or bloody.
-The resident's son took him to the urologist monthly for the indwelling catheter to be changed.

Review of the Care Binder in the SCU revealed:
-Resident #3 needed bathroom assistance.
-There was no documentation Resident #3 had an indwelling catheter.

Telephone interview with Resident #3's responsible family member on 11/09/21 at 2:49pm revealed:
-He was the primary caregiver of Resident #3 and took him to all medical appointments.
-The resident had an appointment with the urologist monthly to exchange the indwelling catheter.
-The resident had a urinary tract infection last month, but did not have a history of infections.
-The urologist never expressed concerns with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 464	Continued From page 64 care of the catheter. Telephone interview with the Executive Director on 10/15/21 at 3:55pm revealed she did not know Resident #3 did not have a care plan. Based on observations, interviews and record review, it was determined Resident #3 was not interviewable. Refer to interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:45am. Refer to interview with District Director of Clinical Services (DDCS) on 11/10/21 at 11:24am. Refer to the interview with the Executive Director on 10/01/21 at 10:58am. _____ Interview with the Health and Wellness Coordinator (HWC) on 11/10/21 at 9:45am revealed: -The Health and Wellness Director (HWD) was responsible for completing the residents' care plans. -The HWD position had been vacant for three months. -She had not completed any care plans for the residents. Interview with District Director of Clinical Services (DDCS) on 11/10/21 at 11:24am revealed: -The facility did not currently have a HWD in the community. -The HWD was responsible for completing the residents' care plans upon admission and annually thereafter, and to assure it was signed by their physician. -The care plan should be completed 14 to 30 days after the resident was admitted to the	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 464	Continued From page 65	D 464		

facility.
-In the special care unit (SCU), the pre-screening assessment performed by the Registered Nurse (RN) for new residents generated a care plan and care tasks for the personal care aides (PCAs).
-She and the Executive Director were responsible for ensuring the HWD's responsibilities were completed until a new HWD was hired.
-They had not conducted an audit of the resident's files since the HWD left.

Telephone interview with the Executive Director on 10/15/21 at 3:55pm revealed:
-The HWD was responsible for completing a care plan for every new resident, as well as an annual care plan ongoing.
-Upon admission, the business office manager (BOM) enters the resident's information into a tracking system spreadsheet.
-This information populated a date for the care plans to be completed.
-The HWD was responsible for checking the spreadsheet to track when these tasks were scheduled to be completed and entered into the tracking system.
-She had not completed an audit of the resident's files.

_____

The failure of the facility to have a physician signed care plan in the special care unit (SCU) to assist the staff in providing the necessary care for the indwelling catheter to prevent recurring urinary tract infections, dressing, grooming and showering needs (Resident #3), the escorting to the dining room for meals to ensure adequate nutritional intake and the need for staff assistance for ambulation to reduce the risk of falls (Resident #2) was detrimental to the health and welfare of these residents and constitutes a Type B Violation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 464	Continued From page 66 The facility provided a plan of protection in accordance with G.S.131D-34 on 11/10/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 30, 2021.	D 464		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 468	Continued From page 67	D 468		

supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

This Rule is not met as evidenced by:
Based on on record review and interviews the facility failed to ensure that 2 of 2 sampled staff (Staff A and E) completed 20 hours of dementia specific training within their 6 months working in the Special Care Unit (SCU) and an additional 6 hours of dementia specific training each year.

The findings are:

1. Review of Staff A's, personal care aide (PCA), personnel record revealed:
-She was hired as PCA on 01/26/21.
-There was no documentation of 20 hours of dementia specific training within the first 6 months of hire.
-There was documentation of 6 hours of dementia specific training for 2021.

Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:25am.

Refer to telephone interview with the Business Office Manager (BOM) on 11/15/21 at 3:20pm.

2. Review of Staff E's, personal care aide (PCA), personnel record revealed:
-She was hired as a PCA on 11/06/16.
-There was no documentation of 20 hours of dementia specific training within the first 6 months of hire.
-There was no documentation of any dementia specific training hours for 2021.

Telephone interview with Staff E on 11/15/21 at 3:35pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 468	Continued From page 68 -She had been working at the facility for approximately 15 years. -She had been through many trainings and could not remember if she received 20 hours of dementia specific training within the first 6 months of working at the facility. -She had been locked out of the facility's computer training system for the last 3-6 months. -She attended 1 or 2 virtual trainings earlier this year that focused on dementia related care. -Each virtual training lasted about 1 hour and was provided by the facility. Refer to interview with the District Director of Clinical Services on 11/10/21 at 11:25am. Refer to telephone interview with the Business Office Manager (BOM) on 11/15/21 at 3:20pm. _____ Interview with the District Director of Clinical Services on 11/10/21 at 11:25am revealed: -It was the responsibility of the Executive Director (ED) and the Health and Wellness Director (HWD) to coordinate training for Special Care Unit (SCU) staff.. -The Business Office Manager (BOM) was responsible for ensuring training records were kept in the employee's file. Telephone interview with the BOM on 11/15/21 at 3:20pm revealed: -It was the responsibility of the SCU coordinator to ensure SCU staff complete the required training. -It was her responsibility to ensure the training documentation was in the employee's file. -She did not have a regular schedule for auditing employee files for completion of required training. -She was in the process of auditing employee files but had not yet completed all of them.	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to healthcare, licensed health professional support and the Special Care Unit resident care plans. The findings are: 1. Based on interviews, observation and record reviews the facility failed to assure the implementation of procedures and treatments as ordered by the physician for 2 of 6 sampled residents related to an order for oxygen saturation levels with as needed (PRN) oxygen (Resident #5), and an order for weights to be taken twice a week to monitor fluid overload (Resident #6). [Refer to tag 276, 10A NCAC 13F .0902(c)(3-4)(Type B Violation)]. 2. Based on observations, interviews and record reviews the facility failed to assure a licensed health professional provided an onsite health evaluation for 1 of 5 sampled residents (Resident #5) who had a physician's order for oxygen via nasal cannula when oxygen saturation levels dropped below 90%. [Refer to Tag 278, 10A	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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
D912	Continued From page 70 NCAC 13F .0903 (Type B Violation)]. 3. Based on record reviews and interviews, the facility failed to assure 2 of 2 sampled residents, (Residents #2, and #3), residing in the Special Care Unit (SCU) had a care plan completed within 30 days of admission to the SCU and signed by a physician. [Refer to Tag 464, 10A NCAC 13F .1307(2) (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following:	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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
D935	Continued From page 71 a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled staff (B, C and D) who administered medications had completed the state approved 5-hour and 10-hour medication aide training course as well as a medication clinical skills evaluation as required. The findings are: 1.Review of Staff B's, medication aide (MA), personnel record revealed: -She was hired on 08/12/21 as a MA. -She completed a 15 hour MA training course on 09/09/21. -She passed the medication exam on 11/04/21. -There was no documentation of completion of the medication clinical skills evaluation. Telephone interview with Staff B on 11/15/21 at 3:16pm revealed: -She was hired in August 2021 as a MA. -She had previously worked as a MA in another state. -She started passing medications 3 days after	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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
D935	Continued From page 72	D935		

she completed her 15 hour MA training course.
-Approximately 1 week after the training course, the Health and Wellness Director (HWD) went through a checklist with her while she was on the medication cart.
-She was not asked to sign the checklist and had not seen the checklist since that day.

Refer to the interview with the District Director of Clinical Services on 11/10/21 at 11:25am.

Refer to the telephone interview with the Business Office Manager (BOM) on 11/15/21 at 3:20pm.

Refer to the telephone interview with the Executive Director on 11/15/21 at 3:55pm.

2. Review of Staff C's, medication aide (MA), personnel record revealed:
-She was hired on 08/10/21 as a MA.
-There was no documentation of completion of the 5,10 or 15 hour MA training.
-She completed the medication clinical skills evaluation on 08/16/21.
-She passed the MA exam on 09/25/21.

Attempted telephone interview with Staff C on 11/15/21 at 3:33pm was unsuccessful.

Refer to the interview with the District Director of Clinical Services on 11/10/21 at 11:25am.

Refer to the telephone interview with the Business Office Manager (BOM) on 11/15/21 at 3:20pm.

Refer to the telephone interview with the Executive Director on 11/15/21 at 3:55pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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
D935	Continued From page 73 3. Review of Staff D's, medication aide (MA), personnel record revealed: -She was hired as a MA on 07/12/21. -There was no documentation of completion of the 5,10 or 15 hour MA training. -She passed the MA exam on 06/22/21. -She completed the medication clinical skills evaluation on 07/04/21. Attempted telephone interview with Staff D on 11/15/21 at 3:35pm was unsuccessful. Refer to the interview with the District Director of Clinical Services on 11/10/21 at 11:25am. Refer to the telephone interview with the Business Office Manager (BOM) on 11/15/21 at 3:20pm. Refer to the telephone interview with the Executive Director on 11/15/21 at 3:55pm. _____ Interview with the District Director of Clinical Services on 11/10/21 at 11:25am revealed: -The Health and Wellness Director (HWD) was responsible for training staff MAs. -The Business Office Manager (BOM) was responsible for ensuring training records were in the employee's file. Telephone interview with the BOM on 11/15/21 at 3:20pm revealed: -It was the responsibility of the HWD to ensure MAs completed the 5, 10, or 15 hour MA training as required. -It was the responsibility of the HWD to complete the medication clinical skills evaluation before the MA could administer medications. -It was her responsibility to ensure the documentation of the 5,10 or 15 hour MA training	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	R-C 11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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
D935	Continued From page 74 and the medication clinical skills evaluation were in the employee's file. -She did not have a regular schedule for auditing employee files. -She was in the process of auditing employee files but had not yet completed all of them. Telephone interview with the Executive Director on 11/15/21 at 3:55pm revealed: -The HWD was responsible for ensuring the MAs completed the required 5, 10 or 15 hour MA training. -The HWD was responsible for completing the MA's medication clinical skills evaluation. -The BOM was responsible for ensuring the documentation was kept in the employee's personnel file.	D935		