STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/04/2024

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BROOKDALE DICKINSON AVENUE	2715 DICKINSON AVENUE GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 01/03/24 and 01/04/24.	D 000		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure care plans for 2 of 5 sampled residents (#3 and #5) were certified by the residents' physician and included the physician's dated signature. The findings are: 1.Review of Resident #3's current FL2 dated 10/05/23 revealed: -Diagnoses included back pain, scoliosis and bilateral lung masses. -The resident required personal care assistance with bathing. Review of Resident #3's Resident Register revealed: -The resident was admitted to the facility on	D 263		

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D 263	Continued From page 1 10/09/23. Review of Resident #3's current Personal Service Plan dated 12/04/23 revealed: -The resident was independent with bathing/showers. -The resident was at risk for falls and used a walker for ambulation. -The Health and Wellness Director (HWD) signed and dated the care plan on 12/04/23. -The Personal Service Plan was not certified, signed and dated by the resident's physician. Observations revealed: -On 01/03/24 at 12:35pm, Resident #3 ambulated with a walker from the dining room to his room. -On 01/04/24 at 9:10am, a walker was observed in Resident #3's room. Interview with Resident #3 on 01/04/24 at 9:10am revealed: -Staff provided assistance with meals, housekeeping and medications. -He was independent with all other ADL tasks and used a walker for ambulation. Interview with a medication aide (MA) on 01/04/24 at 9:00am revealed the resident was usually independent with ADLs but sometimes required staff to assist with ambulation and bathing related to weakness and appearing unsteady while walking with his walker. Interview with the HWD on 01/04/24 at 1:50pm pm revealed: -The Personal Service Plan was used by the facility as a care plan. -She was responsible for completing the care plans and ensuring the physician signed and dated the care plan.	D 263		

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-She was aware Resident #3's care plan had not been signed by the physician.
-She faxed the care plan to the physician on 12/04/23, but there had not been a response from the physician.

Attempted telephone interview with Resident #3's primary care provider (PCP) on 01/04/24 at 10:27am was unsuccessful.

Interview with Executive Director (ED) on 01/04/24 at 2:41pm revealed:
-He had been the ED for approximately two months.
-He was not aware Resident #3's care plan had not been signed and dated by the resident's physician.
-The HWD was responsible for ensuring the care plans were signed and dated by the resident's physician.
-The HWD had a process for tracking care plans and assessments, but the HWD may have gotten behind during the last two months because the Health and Wellness Coordinator (HWC) position had been temporarily vacant.
-A new HWC started on 01/02/24.

2. Review of Resident #5's current FL2 dated 04/04/23 revealed diagnoses included type 2 diabetes mellitus, age related osteoporosis, atherosclerotic heart disease of native coronary.

Review of Resident #5"s current Personal Service Plan (PSP) dated 10/18/23 revealed:
-The resident was independent with all activities of daily living (ADL).
-The resident was ambulatory.
-Resident #5 self-administered their inhaler and blood sugar checks (FSBS).

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D 263	Continued From page 3 -Resident #5 signed and dated the PSP on 10/18/23. -The Health and Wellness Director (HWD) signed and dated the PSP on 10/18/23. -Resident #5's primary care provider (PCP) was certified, signed, and dated the PSP on 01/04/24. Interview with Resident #5 on 01/06/24 at 8:44am revealed she was independent with her ADLs. Interview with the HWD on 01/04/24 at 1:50pm pm revealed: -She completed Resident #5's PSP on 10/18/23. -She faxed the form to the PCP to be signed but could not remember the date. -She was responsible for completing the PSP and ensuring the physician signed and dated the care plan. Interview with Executive Director (ED) on 01/04/24 at 4:28pm revealed: -He was not aware Resident #5's PSP had not been signed and dated by the resident's physician in October 2023. -The HWD had a process for tracking care plans and assessments, but the HWD may have gotten behind during the last two months because the Health and Wellness Coordinator (HWC) position had been temporarily vacant. -The HWD was responsible for ensuring the PSPs were signed and dated by the resident's PCP. Attempted telephone interview with Resident #5's PCP on 01/04/24 at 10:53am was unsuccessful.	D 263		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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10A NCAC 13F .1004 Medication Administration
(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 residents (#6, #7) observed during the medication pass including errors with a medication used control pain (#6) and administer a medication used prevent constipation(#7).

The findings are:

The medication error rate was 6% as evidenced by the observation of 2 errors out of 29 opportunities during the 8:00am medication pass on 01/04/24.

1. Review of Resident #6's current FL-2 dated 07/31/23 revealed diagnoses included dementia and she was constantly disoriented.

Review of an after visit summary from the local hospital emergency department (ED) dated 09/28/23 revealed:
-Resident #6 was seen for acute knee pain.
-There was an order for Lidocaine patch 5% to be applied each day. (Lidocaine 5% patch is a topical medication used to treat pain.)

Observation of the 8:00am medication administration pass on 01/04/24 revealed no

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Lidocaine patch was removed or applied to Resident #6.

Review of Resident #6's electronic medication administration record (eMAR) for January 2024 revealed:
-There was an electronic entry for Lidocaine patch 5% to be applied to affected area one time a day for pain and remove per schedule; removal was scheduled for 7:59am and the the application was scheduled for 8:00am.
-There was documentation Lidocaine patch 5% was not applied or removed on 01/01/24 through 01/04/24 because pharmacy action was required.

Observation of medications on hand for Resident #6 on 01/04/24 at 10:02am revealed there were no Lidocaine 5% patches available for application as ordered.

Observation of Resident #6 on 01/04/24 at 9:58am revealed:
-She was lying in bed.
-Her knees were swollen but the swelling was most notable in her left knee.

Interview with a personal care aide (PCA) on 01/04/24 at 9:57am revealed:
- Resident #6's knees were swollen.
- Resident #6 did not complain of pain but would grimace sometimes when she tried to stand.

Interview with the medication aide (MA) on 01/04/24 at 10:02am revealed Resident #6's knees hurt when the weather changed and it was reported to her by staff that Resident #6 was leaning to her right side on 01/03/24.

Telephone interview with the pharmacist for facility's contracted pharmacy on 01/04/24 at

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10:20am revealed:
-Resident #6 had an order dated 09/28/23 for Lidocaine 5% patches to be applied daily.
-There were 30 patches last dispensed on 09/28/23 for a 30 day supply.
-Resident #6's insurance had requested a prior authorization for payment and the pharmacy and sent the request to the provider in September 2023 but there had been no response so the order had not been dispensed since 09/28/23.
-Resident #6's pain may not have been well controlled without the Lidocaine 5% patch being applied.

Interview with the facility's Health and Wellness Director (HWD) on 01/04/24 at 2:07pm revealed:
-Resident #6's family member took her to the ED for knee pain in September 2023.
-The MA staff should have notified her that Resident #6's medication was not available for administration.
-She would have followed up with the pharmacy and the primary care provider (PCP) if she knew there was an issue with obtaining the medication.

Attempted telephone interview with Resident #6's primary care provider (PCP) on 01/04/24 at 10:40am was unsuccessful.

Based on observation, record review and interviews with staff, it was determined that Resident #6 was not interviewable.

Refer to interview with the MA on 01/04/24 at 10:02am.

Refer to interview with the facility's Health and Wellness Director (HWD) on 01/04/24 at 2:07pm

Refer to interview with the Administrator on

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D 358	Continued From page 7 01/04/24 at 3:56pm. 2. Review of Resident #7's current FL-2 dated 09/12/23 revealed: -Diagnoses included Alzheimer, difficulty walking, muscle wasting and weakness, lack of coordination and history of stroke. -He was intermittently disoriented. Review of Resident #7's physicians orders dated 10/10/23 revealed polyethylene glycol, 17 Gms was to be administered each day for constipation. (Polyethylene glycol is a medication used to treat constipation.) Observation of the 8:00am medication administration pass on 01/04/24 revealed no polyethylene glycol was administered to Resident #7. Review of Resident #7's electronic medication administration record (eMAR) for January 2024 revealed: -There was a computerized entry for polyethylene glycol, 17 Gms to be administered in liquid daily for constipation and scheduled for 8:00am. -There was documentation polyethylene glycol 17 Gms was administered each day from 01/01/24 through 01/03/24. -There was documentation polyethylene glycol was not administered on 01/04/24 because pharmacy action was required. Observations of medications on hand for Resident #7 on 01/04/24 at 10:02am revealed there was no polyethylene glycol powder available for administration as ordered. Telephone interview with the pharmacist for facility's contracted pharmacy on 01/04/24 at	D 358		

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D 358	Continued From page 8 10:20am revealed: -Polyethylene glycol was last ordered and dispensed on 04/17/23. -There was no active refill request in the system that she could see. -The medication was an over-the counter medication that may be provided by the family. Interview with the medication aide (MA) on 01/04/24 at 10:02am revealed Resident #7 had not been observed to be constipated and she did not remember when it was last administered. Telephone interview with Resident #7's family member on 01/04/24 at 2:51pm revealed: - Resident #7 experienced some constipation approximately one month ago due to a medication he was taking. -Family provided incontinence supplies but did not provide any medications including polyethylene glycol. Telephone interview with the hospice nurse for Resident #7 on 01/04/24 at 10:45am revealed: -Resident #7 was started on polyethylene glycol 09/30/23 as part of a bowel regimen to prevent constipation which was a possible side of effect of a narcotic medication he was previously prescribed. -The medication order was usually sent electronically to the pharmacy with 4-5 refills and the facility was responsible for requesting refills as they were needed. -Resident #7 was no longer on a narcotic medication and he was not having issues with constipation. Attempted telephone interview with Resident #7's primary care provider (PCP) on 01/04/24 at 10:35am was unsuccessful.	D 358		

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D 358	Continued From page 9 Refer to interview with the MA on 01/04/24 at 10:02am. Refer to interview with the facility's Health and Wellness Director (HWD) on 01/04/24 at 2:07pm Refer to interview with the Administrator on 01/04/24 at 3:56pm. _____ Interview with the MA on 01/04/24 at 10:02am revealed: -Medication refills were to be requested 3-5 days before medications ran out. -Some medication refills could be requested on the computer but refills could be faxed or called in to the pharmacy directly. -MAs were responsible for requesting refills but not all MAs requested the refills like they should. -There was no routine cart audit to ensure medications were available for administration. Interview with the facility's Health and Wellness Director (HWD) on 01/04/24 at 2:07pm revealed: -There was no routine oversight to ensure medications were always available for administration and exception reports were not reviewed for missed medication. -MAs were expected to request refills when the number of doses started to run low but there was no process to give a specific time for reorder. Interview with the Administrator on 01/04/24 at 3:56pm revealed: -Medication refills should have been requested in a 5-7 day window prior to the medication running out. -The facility's HWC left in November 2023 which created an increased workload for the HWD; this contributed to some things falling through the	D 358		

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D 358	Continued From page 10 cracks since checks and balances were not completed as they should. -The facility staff failed to follow-up on medication refill requests. -Exception notes were not routinely reviewed but staff had the opportunity to address medication issues in daily stand-up meetings. -Resident care needs were not being met effectively if medications were not administered as ordered.	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, (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 observations, interviews, and record	D 367		

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reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 residents (#7) observed during the medication administration pass on 01/04/24 including inaccurate documentation of a medication used to treat constipation.

The findings are:

Review of Resident #7's current FL-2 dated 09/12/23 revealed:
-He was admitted to the facility on 11/07/22.
-Diagnoses included Alzheimer, difficulty walking, muscle wasting and weakness, lack of coordination and history of stroke.
-He was intermittently disoriented.

Review of Resident #7's physicians orders dated 10/10/23 revealed polyethylene glycol, 17 Gms was to be administered each day for constipation. (Polyethylene glycol is a medication used to treat constipation.)

Review of Resident #7's electronic medication administration record (eMAR) for January 2024 revealed:
-There was a computerized entry for polyethylene glycol, 17 Gms to be administered in liquid daily for constipation and scheduled for 8:00am.
-There was documentation polyethylene glycol was administered each day at 8:00am on 01/01/24 through 01/03/24.
-There was documentation polyethylene glycol was not administered on 01/04/24 because pharmacy action was required.

Observation of medications on hand for Resident #7 on 01/04/24 at 10:02am revealed there was no polyethylene glycol powder available for administration as ordered.

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D 367	Continued From page 12 Telephone interview with the pharmacist for facility's contracted pharmacy on 01/04/24 at 10:20am revealed: -Polyethylene glycol was last ordered and dispensed on 04/17/23. -There was no active refill request in the system that she could see. -The medication was an over-the counter medication that may be provided by the family. Telephone interview with Resident #7's family member on 01/04/24 at 2:51pm revealed: - Resident #7 experienced some constipation approximately one month prior due to a medication he was taking. -Family provided incontinence supplies but did not provide any medications. Interview with the medication aide (MA) on 01/04/24 at 10:02am revealed: -Resident #7's polyethylene glycol was not available for administration. -When a medication was not administered, she always documented on the eMAR that the medication was not given and the reason. -She saw MAs document that a medication was administered when the medication was not available in the past. Interview with the facility's Health and Wellness Director (HWD) on 01/04/24 at 2:07pm and 3:45pm revealed: -It was important the eMAR accurately reflect medications given and not given to ensure resident conditions were treated appropriately. -MAs were trained during new hire on-boarding to document medication administration accurately. Interview with the Administrator on 01/04/24 at	D 367		

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D 367	Continued From page 13 3:56pm revealed: -All medication were dispensed by the pharmacy including over-the counter medications. -Staff could not administer a medication if it was not available for administration. -If polyethylene glycol had not been dispensed since April 2023, it could not have been administered in January 2024 as documented. -Staff were expected to document when a medication was not administered and document the reason in exception note on the eMAR. -The eMAR should be accurate to to ensure medications were administered as ordered. Attempted telephone interview with Resident #7's primary care provider (PCP) on 01/04/24 at 10:35am was unsuccessful. Based on observation, record review and interviews, it was determined that Resident #7 was not interviewable.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures by 1 of 2 medication aides (MA), observed during the	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074011	A. BUILDING: _____ B. WING _____	R 01/04/2024

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

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D 371	Continued From page 14 8:00am medication pass on 01/04/24, who did not sanitize her hands between the preparation and administration of multiple oral medications to residents, including feeding crushed medications in applesauce to a resident, to prevent the transmission of disease and infection, to prevent cross-contamination, and provide a safe and sanitary environment for residents. The findings are: Review of the facility's medication/treatment administration policy and procedure updated 10/2023 revealed: -Staff administering medications should use infection control and prevention practices based on Centers for Disease Control and Prevention guidelines for hand hygiene. -Staff should wash their hands or use hand sanitizer prior to medication administration for each resident. Observation of a medication aide (MA) administering medications in the special care unit (SCU) during the 8:00am medication pass on 01/04/24 from 7:55am through 8: 36am revealed: -There was a bottle of hand sanitizer on a medication cart located beside the medication care in use for the SCU. -The MA did not sanitize or wash her hands prior to preparing medications for a resident. -The MA prepared and administered crushed oral medications in applesauce to the resident at 8:00am. -The MA fed the applesauce with crushed medications to the resident with gloved hands that she donned immediately after crushing the medication adding them to the applesauce for administration. -The MA removed her gloves, returned to the	D 371		

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D 371	Continued From page 15	D 371		

medication cart and used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.
-The MA prepared and administered oral medications to a second resident at 8:06am.
-The MA put the medication cup to the resident's mouth and held the water cup to the resident's mouth with ungloved hands.
-The MA returned to the medication cart and used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.
-The MA prepared and administered oral medications to a third resident at 8:11am.
-The MA returned to the medication cart and used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.
-The MA prepared and administered oral medications to a forth resident at 8:34am.
-The MA donned gloves and checked the resident's blood pressure prior to the administration of medications.
-The MA removed her gloves, returned to the medication cart and used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.
-The MA began preparing medications for the next resident at 8:36am.

Interview with the MA in the SCU on 01/04/24 at 8:36am revealed:
-She wore gloves whenever there was person to person contact with residents but she did not always use hand sanitizer or wash her hands when administering medications unless she touched a resident.
-She had to touch door knobs, light switches and other surfaces when entering a resident room.
-There was a recent outbreak of 10 residents in

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D 371	Continued From page 16	D 371		

the SCU that had COVID and she had COVID just over a week prior so she should have been using hand sanitizer.
-She was not expecting to be administering medications at 8:00am on 01/04/24 but she came in to help with staffing and was tired.

Interview with the facility's Health and Wellness Director on 01/04/24 at 2:07pm revealed:
-MAs should use hand sanitizer after administering medication to each resident.
-The SCU resident had decreased immune systems and there was recent COVID infection in the facility.
-Infection control training was completed upon hire and annually for all staff.
-There was no routine monitoring to ensure hand hygiene practices were done.

Interview with the Administrator on 01/04/24 at 3:56pm revealed:
-MAs should perform hand hygiene between each resident when preparing and administering medications.
-Not performing hand hygiene could spread infection or contaminate resident medications.