STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 and Moore County Department of Social Services conducted an annual and follow-up survey on January 11 to 12, 2024.	D 000		
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 for 1 of 3 residents (#4) observed during the medication pass including errors with medications to treat depression and slow the progression of Alzheimer's disease. The findings are: Review of the facility's medication administration policy dated 03/31/2022 revealed: -Medications/treatments would be provided in a safe and timely manner according and as prescribed by the resident's physician/healthcare provider. -Medication assistance and administration should be in accordance with the prescriber's orders. -The primary care provider (PCP) should be notified when a resident was out of their	D 358		

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medications and if a refill was needed to be prescribed by the PCP.

1. The medication error rate was 8% as evidenced by 2 errors out of 25 opportunities during the 8:00am medication pass on 01/12/24.

a. Review of Resident #4's current FL-2 dated 12/05/23 revealed:
-Diagnoses included Alzheimer's disease with late onset, post-concussional syndrome, metabolic encephalopathy, and dementia.
-There was an order for citalopram 10mg (used to treat depression) take 2 tablets by mouth every morning.

Observation of the 8:00am medication pass on 01/12/24 revealed the medication aide (MA) prepared morning medications for Resident #4 which did not include her citalopram.

Observation of Resident #4's medications on hand on 01/12/24 at 11:06am revealed there was no citalopram 10mg available for administration.

Review of Resident #4's January 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for citalopram 10mg take 2 tablets by mouth every morning scheduled at 8:00am.
-Citalopram was documented as not administered from 01/01/24 to 01/06/24, 01/08/24 to 01/10/24, and on 01/12/24.
-The reason listed for citalopram not being administered was documented as 09 (other/see nurses notes) from 01/02/24 to 01/06/24 and 01/08/24 to 01/10/24 8:00am.
-The reason listed for citalopram not being administered was documented as 16 (pharmacy

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action required) on 01/01/24 and 01/12/24 at 8:00am.

Attempted telephone interview with Resident #4's power of attorney (POA) on 01/12/24 at 2:35pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.

Refer to interview with the medication aide (MA) on 01/12/24 at 11:10am.

Refer to interview with the Executive Director on 10/12/24 at 2:40pm.

Refer to interview with the facility's Registered Nurse (RN) on 01/12/24 at 11:58am.

Refer to telephone interview with the pharmacist at the facility's contracted pharmacist on 01/12/24 at 11:02am.

Refer to telephone interview with Resident #4's primary care provider (PCP) on 01/12/24 at 2:20pm.

b. Review of Resident #4's current FL-2 dated 12/05/23 revealed:
-Diagnoses included Alzheimer's disease with late onset, post-concussional syndrome, metabolic encephalopathy, and dementia.
-There was an order for memantine 10mg (used to slow the progression of Alzheimer's disease) give one in the morning and one at bedtime.

Review of Resident #4's January 2024 electronic medication administration record (eMAR) revealed:

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D 358	Continued From page 3 -There was an entry for memantine 10mg give one in the morning and one at bedtime scheduled at 8:00am and 8:00pm. -Memantine 10mg was documented as not administered from 01/08/24 to 01/12/24 at 8:00am and from 01/08/24 to 01/11/24 at 8:00pm. -The reason listed for memantine not being administered was documented as 09 (other/see nurses notes) from 01/08/24 to 01/11/24 at 8:00am and on 01/10/24 at 8:00pm. -The reason listed for memantine not being administered was documented as 16 (pharmacy action required) on 01/08/24 and 01/11/24 at 8:00pm and on 01/12/24 at 8:00am. Observation of the 8:00am medication pass on 01/12/24 revealed the medication aide (MA) prepared morning medications for Resident #4 which did not include her memantine. Observation of Resident #4's medications on hand on 01/12/24 at 11:06am revealed there was no memantine 10mg available for administration. Attempted telephone interview with Resident #4's power of attorney (POA) on 01/12/24 at 2:35pm was unsuccessful. Based on observations, interviews, and record review, it was determined that Resident #4 was not interviewable. Refer to interview with the medication aide (MA) on 01/12/24 at 11:10am. Refer to interview with the Executive Director on 10/12/24 at 2:40pm. Refer to interview with the facility's Registered Nurse (RN) on 01/12/24 at 11:58am.	D 358		

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D 358	Continued From page 4 Refer to telephone interview with the pharmacist at the facility's contracted pharmacist on 01/12/24 at 11:02am. Refer to telephone interview with Resident #4's primary care provider (PCP) on 01/12/24 at 2:20pm. 2. Review of Resident #4's current FL-2 dated 12/05/23 revealed: -Diagnoses included Alzheimer's disease with late onset, post-concussional syndrome, metabolic encephalopathy, and dementia. -There was an order for levothyroxine 100mcg (used to treat hypothyroidism) give one in the morning. Review of Resident #4's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for levothyroxine 100mcg give one in the morning scheduled at 6:30am. -Levothyroxine was documented as not administered from 01/09/24 to 01/12/24 at 6:30am. -The reason listed for levothyroxine not being administered was documented as 05 (hold/see nurses notes) on 01/09/24 at 6:30am -The reason listed for levothyroxine not being administered was documented as 09 (other/see nurses notes) from 01/10/24 at 6:30am -The reason listed for levothyroxine not being administered was documented as 16 (pharmacy action required) on 01/11/24 and 01/11/24 at 6:30am. Observation of Resident #4's medications on hand on 01/12/24 at 11:06am revealed there was no levothyroxine 100mcg available for	D 358		

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D 358	Continued From page 5 administration. Attempted telephone interview with Resident #4's power of attorney (POA) on 01/12/24 at 2:35pm was unsuccessful. Based on observations, interviews, and record review, it was determined that Resident #4 was not interviewable. Refer to interview with the medication aide (MA) on 01/12/24 at 11:10am. Refer to interview with the Executive Director on 10/12/24 at 2:40pm. Refer to interview with the facility's Registered Nurse (RN) on 01/12/24 at 11:58am. Refer to telephone interview with the pharmacist at the facility's contracted pharmacist on 01/12/24 at 11:02am. _____ Interview with the medication aide (MA) on 01/12/24 at 11:10am revealed: -Resident #4 did not use the facility's contracted pharmacy. -Resident #4's family member provided her medications. -The facility had contacted the family member on 12/20/23, but the medications had not been received at the facility as of 01/12/24. Interview with the Executive Director on 10/12/24 at 2:40pm revealed: -If a resident ran out of medication, the MAs were to notify the Resident Care Coordinator (RCC) or the facility's Registered Nurse (RN). -Resident #4's family member provided her medications at the family member's request.	D 358		

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-Resident #4's family member wanted to keep using Resident #4's current mail order pharmacy.
-The family member lived out of state.
-The facility had a care plan meeting last week with the family member (responsible for the medications) along with another family member regarding Resident #4's care and medications.
-The family member would provide the medications needed for Resident #4 or the facility would have to utilize the facility's contracted pharmacy to provide the medications.

Interview with the facility's Registered Nurse (RN) on 01/12/24 at 11:58am revealed:
-Resident #4 did not use the facility's contracted pharmacy.
-Resident #4's family provided her medication which was done through a mail program.
-She had done an audit on Resident #4's medications when she was admitted to the facility on 12/03/23.
-She had found numerous medications that were mixed in one bottle when Resident #4 was admitted.
-The family member had been contacted on 12/20/23 to get the medication refills in for Resident #4 but so far, they had not been received.
-The MAs were responsible for contacting the primary care provider (PCP) when the resident missed doses of their medications.
-The MAs were responsible for ordering the refills from the medication packs.
-If no refills were available, the MAs were responsible for contacting the PCP to get a new order.
-The MAs documented in the nurses notes when medications were missed, refused, etcetera. with the reasons, when the PCP was contacted, when the pharmacy was contacted, if the resident was

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D 358	Continued From page 7 showing any behaviors or having any problems. -The facility would order Resident #4's medications through their contracted pharmacy until the family provided the resident's medications to the facility. Telephone interview with the pharmacist at the facility's contracted pharmacist on 01/12/24 at 11:02am revealed: -Resident #4 was not a resident to whom the pharmacy dispensed medications. -Resident #4 was only listed in their system as a 'profile only' meaning she did not use their pharmacy for her medications. -The pharmacy had not dispensed any medications for Resident #4 since her admission date of 12/03/23. -The pharmacy had not received any prescriptions for Resident #4 since her admission date of 12/03/23. Telephone interview with Resident #4's PCP on 01/12/24 at 2:20pm revealed: -She was not aware that Resident #4 had missed any of her medications. -She expected to be notified if residents did not have medications available for administration.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by:	D 438		

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Based on record reviews and interviews, the facility failed to notify the North Carolina Health Care Personnel Registry (HCPR) of injuries of unknown cause for 1 of 3 sampled residents (#1)

The findings are:

Review of Resident #1's current FL-2 dated 07/11/24 revealed diagnoses included dementia, hypertension, acute pain, and glaucoma.

Review of Resident #1's accident/incident report dated 07/04/23 revealed:
- The resident sustained injuries of unknown origin.
-There was bruising to the back side of the right hand with swelling.
-There was no documentation a 24-hour report or 5-day investigation report regarding injuries of unknown cause were sent to HCPR.

Review of Resident #1's accident/incident report dated 08/04/23 revealed:
-A medication aide (MA) observed Resident #1 on her right side next to the bed; it appeared she had fallen out of bed.
-The right side of the resident's forehead, eye, and cheek were bruised, red, and swollen.
-The resident was sent to the emergency room for further evaluation.
-There was no documentation a 24-hour report or 5-day investigation report regarding injuries of unknown cause were sent to HCPR.

Review of Resident #1's accident/incident report dated 09/15/23 revealed:
-The resident sustained injuries of unknown origin.
-An MA assisted the resident to the bathroom for toileting when she observed a bruise on the

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resident's right hip and right lower leg.
-There was no documentation a 24-hour report or 5-day investigation report regarding injuries of unknown cause were sent to HCPR

Interview with a personal care aide (PCA) on 01/12/24 at 11:07am revealed:
-She observed bruises last year (August and September 2023) on multiple areas of Resident #1's body and did not know what caused it but she notified the MA.
-She did not know if the injury had been reported to the HCPR.

Interview with a MA on 01/12/24 at 11:40am revealed:
-She saw bruising on multiple areas of Resident #1's in August and September 2023 but did not know the origin.
-She documented the injury and notified the Resident Care Coordinator (RCC).
-She did not know if a report had been sent to HCPR for Resident #1's injuries of unknown cause sustained in September and October 2023.

Interview with the Clinical Service Specialist (CSS) on 01/12/24 at 2:40pm revealed:
-The RCC was on leave and not available for an interview.
-She was aware that Resident #1 had bruises of unknown origin.
-The facility should have reported the injuries of unknown origin to the HCPR but she could not find any records that this happened.

Telephone interview with the Cooperate Area Nurse Manager on 01/12/24 at 2:58pm revealed:
-She was aware that Resident #1 had fallen and had reports of injuries of unknown cause.
-She did not know if the resident's injuries of

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D 438	Continued From page 10 unknown origin that were documented on the August and September 2023 incident reports had been reported to the HCPR. -For all incident/accident reports, the staff notified the nurse, who notified the PCP, and the nurse notified the responsible party. -Incident/accident reports for injuries of unknown cause should be reported within 24 hours (the initial report) and 5 days (investigation report) to the HCPR. Interview with the Administrator on 01/12/24 at 3:18 pm revealed: -He was aware that Resident #1 had fallen and had reports of injuries of unknown cause. -The RCC was responsible for reporting any injuries of unknown origin to the HCPR. -He did not know if the incident/accident report was reported to the HCPR. -He could not find any HCPR reports of injuries of unknown cause for Resident #1. Interview with the County Adult Home Specialist (AHS) on 01/12/24 at 3:47 pm revealed if a resident sustained an injury of unknown cause, the facility was required to complete an incident/accident report and send an initial report to HCPR within 24 hours along with an investigation report within 5 days. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents	D 451		

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D 451	Continued From page 11 (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the county Department of Social Services (DSS) of injuries that required treatment at the Emergency room (ER) and injuries of unknown cause for 1 of 3 sampled residents (#1). The findings are: Review of the facility's Accident/Incident Policy revealed: -An incident report must be completed in the event that a resident or a visitor experiences an occurrence that is unusual, improper, or harmful. -Incidents may include, but are not limited to, injuries, falls, theft, unexplained absence, sudden illness, and combative behavior. -The resident's physician, family, responsible person, and sponsoring agency, if applicable, should be notified. -Incidents or accidents resulting in death or requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid shall be reported to the county DSS. -The completed report should be submitted to the county DSS by mail, fax, electronic mail, or in person within 48 hours of associates' initial discovery or knowledge of the accident or incident.	D 451		

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D 451	Continued From page 12 Review of Resident #1's current FL-2 dated 07/11/24 revealed diagnoses included dementia, hypertension, acute pain, and glaucoma. Review of Resident #1's accident/incident report dated 07/04/23 revealed: - The resident sustained injuries of unknown origin. -There was bruising to the back side of the right hand with swelling. -The facility did not contact the county DSS to report the injury of unknown origin. Review of Resident #1's accident/incident report dated 08/04/23 revealed: -A medication aide (MA) observed Resident #1 on her right side next to the bed; it appeared she had fallen out of bed. -The right side of the resident's forehead, eye, and cheek were bruised, red, and swollen. -The resident was sent to the emergency room for further evaluation. -The staff did not report the incident to the county DSS. Review of Resident #1's accident/incident report dated 09/15/23 revealed: -The resident sustained injuries of unknown origin. -An MA assisted the resident to the bathroom for toileting when she observed a bruise on the resident's right hip and right lower leg. -The facility did not report the resident's injuries of unknown origin to the county DSS. Review of Resident #1's accident/ incident report dated 09/28/23 revealed: -Resident #1 was found at the bedside after a fall.	D 451		

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D 451	Continued From page 13 -The resident sustained a scrape/abrasion on her skull/scalp. -The resident was sent to the emergency room (ER). -The facility did not report the residents' injuries to the county DSS. Review of Resident #1's accident and incident report dated 12/14/23 revealed: -Resident #1 was found in her bedroom from an apparent fall. -The resident sustained a skin tear on her left wrist. -The resident was not sent for outside treatment. -The facility did not report the residents' injury to the county DSS. Interview with a personal care aide (PCA) on 01/12/24 at 11:07 am revealed: -Resident #1 fell more at night or late evenings. -When she saw a bruise and did not know what caused it, she notified the MA. -She did not know if the injury had been reported to DSS. Interview with a MA on 01/12/24 at 11:40 am revealed: -Resident #1 was getting weaker and attempted to get out of bed alone, and one foot was caught in the covers in October or November 2023. -She saw a bruises on multiple areas of the resident's body in August and September 2023 but did not know how the injuries occurred. -She documented the injuries and notified the Resident Care Coordinator (RCC). -When a resident fell, she documented the fall in the alter charting system and reported the fall to the primary care provider (PCP), the family member, and the Resident Care Coordinator.	D 451		

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 01/12/2024

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

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D 451	Continued From page 14 Interview with the Clinical Service Specialist (CSS) on 01/12/24 at 2:40 pm revealed: -The RCC was on leave and not available for an interview. -She was aware that the resident had bruises of unknown origin. -Her concerns were to keep Resident #1 safe from harm. -The facility should have reported the injuries of unknown origin to the county DSS, but she could not find any records that this happened. -She was new to the position and was not aware of the process of reporting resident injuries. Telephone interview with the Cooperate Area Nurse Manager on 01/12/24 at 2:58 pm revealed: -She was aware that Resident #1 had fallen. -A fall incident happened in October 2023, but she did not know if the county DSS was notified. -She did not know if the injury of unknown origin was reported. -There was a fall management process in which an investigation tool was used to investigate when a resident fell, their discomfort/pain level, and what happened before, during, or after the behavior. -For all incident/accident reports, the staff notified the nurse, who notified the PCP, and the nurse notified the responsible party. -Incident/accident reports should be sent within 24 hours to the county DSS. Interview with the Administrator on 01/12/24 at 3:18 pm revealed: -He was aware that Resident #1 had fallen. -The RCC was responsible for reporting any fall incidents to the county DSS. -He was not aware if the incident/accident report was sent to the county DSS.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 451	Continued From page 15 Interview with the County Adult Home Specialist (AHS) on 01/12/24 at 3:47 pm revealed: -If the facility staff did not witness a resident incident and the resident said they fell or if there were visible injuries, an incident/accident report should be faxed or emailed to DSS within 24 hours if the resident was sent to the ER for evaluation or treatment. -If a resident sustained an injury of unknown cause, the facility was required to complete an incident accident report and send the report to HCPR and the county DSS (AHS) within 24 hours. -Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.	D 451		