STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032016	A. BUILDING: _____ B. WING _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHAPEL HILL AL (NC)	2220 FARMINGTON DRIVE CHAPEL HILL, NC 27514

(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 survey on December 3, 2024 through December 5, 2024.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure exit doors were equipped with a sounding device that activated when the doors were opened, which were accessible by residents, including a resident (#2) who was intermittently disoriented. The findings are: Review of Resident #2's current FL-2 dated 11/12/24 revealed: -Diagnoses included dementia, mild cognitive impairment, attention deficit hyperactivity disorder, depression, and anxiety. -She was intermittently disoriented.	D 067		

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D 067	Continued From page 1 -She was semi-ambulatory. Review of Resident #2's care plan dated 11/18/24 revealed: -Resident #2 was independent with mobility. -Resident #2 needed assistance with medication management. -Resident#2 needed assistance with showering. -Resident #2 was independent with dressing and grooming. -Resident #2 needed assistance with toileting. Review of Resident #2's primary care provider (PCP) after-visit summary dated 10/29/24 revealed: -Resident #2 had moderate vascular dementia. -No wandering or exit seeking behaviors had been reported. -Plan was to continue to reside in an assisted living facility. -Staff to provide a safe and secure environment. Observation of the front door on 12/03/24-12/05/24 at various times between 8:00am-5:00pm revealed: -There was no audible alarm when the front door was opened. -There was a receptionist area at the front door, but there was no receptionist at the desk on multiple occasions. Observation of the B-hall on 12/03/24 at 4:16pm revealed: -Each hall had a common area/sitting room for the residents. -There was an exit door in the common area/sitting room. -The sitting room was the room immediately beside Resident #2's room. -There was no audible alarm when the door was	D 067		

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D 067	Continued From page 2	D 067		

opened.
-Resident #2 was standing at the door in her room.
-There were no staff in the hallway.

Interview with Resident #2 on 12/04/24 at 10:09am revealed:
-She liked to go outside when it was warm.
-She did not need anyone to go outside with her.

Telephone interview with Resident #2's family member on 12/05/24 at 3:44pm revealed:
-Resident #2 had "early" Alzheimer's.
-She was not concerned Resident #2 would go outside because the resident knew her limitations.
-She did not think Resident #2 would go outside on her own because the resident was at risk for falls.
-Resident #2 usually only went outside if she was going with staff or family.

Interview with a resident on 12/04/24 at 11:30am revealed:
-She self-administered her medications.
-She locked her door when she left her room because she kept medications in her room.
-There was a resident who tried to come in her room and she needed to keep her medications safe.

Interview with a personal care aide (PCA) on 12/05/24 at 3:15pm revealed:
-The front door was not alarmed when she entered the facility.
-She did go to work one day early and the front door was locked.
-She had not heard any alarms when she exited a door from the hallway.
-She did not think Resident #2 would go "far" by

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D 067	Continued From page 3	D 067		

herself.
-Resident #2 was a creature of habit and would not go anywhere.

Interview with a second PCA on 12/05/24 at 2:45pm revealed:
-The doors were locked at 9:00pm each night.
-If there was an attempt to exit the door after 9:00pm the alarm on the pages would sound.
-The pager would notify the facility staff which door set off the alarm and the facility staff would check the specific door.

Telephone interview with a medication aide (MA) on 12/05/24 at 1:34pm revealed:
-The exit doors at the facility were not alarmed during the day.
-The exit doors were locked at 10:00pm.
-Residents were allowed to go outside unsupervised but if a resident was forgetful the resident might walk to the road.
-Resident #2 was forgetful.

Telephone interview with a second MA on 12/05/24 at 2:21pm revealed:
-Residents could go in and out of the facility at any time.
-Residents were asked to sign in and out of the facility.
-The front door to the facility was not alarmed.
-She knew the doors in the stairwells were alarmed.
-She thought the exit doors in the sitting areas were alarmed.
-She had never heard a door alarm sound.
-Resident #2's memory was better on some days than others.
-Resident #2 did have a cognitive impairment.
-She would not trust Resident #2 going outside by herself because she might leave the porch area,

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D 067	Continued From page 4 but also because the resident had a lot of leg pain and might need to sit down. Telephone interview with the facility's contracted PCP on 12/04/24 at 3:26pm revealed: -Resident #2's cognition had declined a lot. -Resident #2 was super forgetful. -Resident #2 was at risk of wandering and was "high" on her radar. Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:05pm revealed: -The facility did not have door alarms during the day. -Resident #2's memory was "all over the place." -One-minute Resident #2 was coherent and the next she might be babbling. -The staff "knew our residents" and Resident #2 was not going to step near the exit door; Resident #2 had never tried. -If Resident #2 went outside, the resident could get turned around and wander from the facility. Interview with the Administrator on 12/05/24 at 4:59pm revealed: -Residents could sign in and out of the facility. -He did not know if a resident was intermittently disoriented the doors needed to have a sounding device. -Resident #2 leaving the facility could potentially be a concern but he had not heard anything about the resident wandering.	D 067		
D 195	10A NCAC 13F .0608 (c-f) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents	D 195		

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D 195	Continued From page 5 (c) The aide shall provide personal care services and supervision needed by the residents. (d) Aides shall not provide housekeeping duties except: (1) Between the hours of 7:00 a.m. to 9:00 p.m.: (A) to prevent an accident or injury; (B) when occasionally attending to an individual resident housekeeping need; and (C) when the number of aides on duty exceeds the minimum required by Paragraph (a) of this Rule. (2) Between the hours of 9:00 p.m. to 7:00 a.m., as long as the housekeeping duties do not: (A) hinder the aide's care of residents or immediate response to resident calls; (B) do not disrupt the residents' normal lifestyles and sleeping patterns; and (C) do not take the aide out of view of where the residents are as the aide shall be prepared to care for the residents since that remains his or her primary duty. (e) Aides shall not be assigned food service duties except when providing assistance to individual residents who need help with eating and carrying plates, trays, or beverages to residents. (f) In addition to the staffing required for management and aide duties, there shall be additional staff to perform housekeeping and food service duties. Note: The following chart illustrates the required aide, supervisory and management staffing requirements for each eight-hour shift in facilities with a census of 21 or more residents according to Rules .0602, .0603, .0604, .0608, and .0609 of this Section.	D 195		

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Bed Count Position Type First Shift Second Shift Third Shift
21 - 30 Aide 16 16 8
Supervisor Not Required Not Required Not Required
Administrator In the building, or within 500 feet and immediately available.
31-40 Aide 16 16 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
41-50 Aide 20 20 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
51-60 Aide 24 24 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
61-70 Aide 28 28 24
Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
71-80 Aide 32 32 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
81-90 Aide 36 36 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
91-100 Aide 40 40 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

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101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
151-160 Aide 64 64 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
161-170 Aide 68 68 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
171-180 Aide 72 72 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
181-190 Aide 76 76 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
191-200 Aide 80 80 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40

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hours. When not in facility, on call.
201-210 Aide 84 84 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
211-220 Aide 88 88 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
221-230 Aide 92 92 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
231-240 Aide 96 96 64
Supervisor 24 24 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure personal care aides were not routinely assigned to perform food service duties such as setting the dining tables, serving meals, clearing used place settings from the tables, cleaning dining room tables, and cleaning the kitchenettes.

The findings are:

Observation of the facility on 12/03/24 at 9:00am revealed:
-The first floor of the facility had a small dining room in each hallway; there were 3 halls.
-The second floor of the facility had a small dining

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room in each hallway; there were 3 halls.

Review of the facility's census dated 12/03/24 revealed a current census of 47.

Review of the facility's staff assignment sheet revealed a medication aide (MA) and a personal care aide (PCA) assigned to each floor.

Observation of the lunch meal in the dining room on 12/04/24 between 8:11am-9:47am revealed:
-At 8:11am, the personal care aide (PCA) served beverages to the residents at the tables.
-As residents entered the dining room, the PCA served them beverages and food.
-At 9:11am, the MA was observed assisting the PCA with meals.
-At 9:40am, the MA returned to her medication cart.
-At 9:47am, residents remained in all 3 dining rooms.
-The PCA cleaned the tables after each resident finished eating.

Interview with the PCA on 12/04/24 at 8:16am and 11:08am revealed:
-Dietary services delivered the food cart to the second floor.
-She served meals to the residents in 3 dining rooms on the second floor.
-The PCA was responsible for putting beverages in pitchers, serving the residents meals, cleaning up the dining room after meals, and taking the food cart and dirty dishes downstairs to the kitchen after each meal.

Interview with another PCA on 12/05/24 at 3:15pm revealed:
-She assisted with meals when she worked.
-The PCAs were responsible for cleaning the

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kitchenettes each shift.
-The PCAs wiped down the counters, swept the floor, and cleaned inside the microwave.
-MAs were good at helping with setting up and breaking down the dining rooms before and after meals.

Interview with a MA on 12/05/24 at 1:20pm revealed:
-She passed medications from 7:30am-8:30am.
-She helped set tables up, serve meals, clean tables up, fill out menus for the next meal, and deliver room trays in between her medication passes.
-She assisted with meals for about 45-60 minutes.
-She usually finished her morning medication pass around 10:30am.
-The PCAs were responsible for cleaning the kitchenettes on each floor but if she was something dirty, she would wipe it down.

Interview with the Dietary Manager (DM) on 12/05/24 at 2:47pm revealed the 3rd shift care staff (PCAs/MAs) were responsible for breaking down the kitchenette and cleaning.

Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:05pm revealed the PCAs and MAs served meals, cleaned up after the meals, took the used dishes to the kitchen, and reset the dining rooms for the next meals.

Interview with the Administrator on 12/05/24 at 4:59pm revealed:
-The PCAs and MAs were responsible for setting up the dining rooms, serving meals, and cleaning the dining rooms after meals.
-He did not know the clinical staff should not be responsible for these tasks.

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D 195	Continued From page 11 -Managers also helped with serving meals and cleaning up after the meals.	D 195		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 2 of 5 sampled residents (#3 and #4) related to an order for thrombo-embolic deterrent (TED) hose (compression stockings that help control swelling in the legs) (#3) and a resident wearing TED hose without an order (#4). 1. Review of Resident #3's current FL2 dated 09/05/24 revealed diagnoses included malnutrition of moderate degree, heart failure, chronic pain, respiratory failure, coronary artery disease, gastroesophageal reflux disease, and hyperlipidemia. Review of a physician's order dated 07/16/2024 revealed an order for TED hose apply every morning and remove at bedtime. Review of Resident #3's October 2024 electronic medication administration record (eMAR) revealed:	D 276		

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-There was an entry for TED hose apply every morning and remove at bedtime scheduled to be applied at 6:00am and removed at 6:00pm.
-There was documentation Resident #3's TED hose were applied for 31 of 31 opportunities from 10/01/24 to 10/31/24.

Review of Resident #3's November 2024 eMAR revealed:
-There was an entry for TED hose apply every morning and remove at bedtime scheduled to be applied at 6:00am and removed at 6:00pm.
-There was documentation Resident #3's TED hose were applied for 30 of 30 opportunities from 11/01/24 to 11/30/24.

Review of Resident #3's December 2024 eMAR from 12/01/24-12/03/24 revealed:
-There was an entry for TED hose apply to every morning and remove at bedtime scheduled to be applied at 6:00am and removed at 6:00pm.
-There was documentation Resident #3's TED hose were applied for 3 of 3 opportunities from 12/01/24 to 12/03/24.

Observations of Resident #3 on 12/03/24 revealed:
-At 8:56am, Resident #3 was sitting in the dining room without TED hose.
-At 11:57am, Resident #3 was sitting in the dining room without TED hose; no swelling in the resident's leg was observed.

Interview with a first shift Personal Care Aide (PCA) on 12/03/24 at 1:21pm revealed:
-The PCA was not aware Resident #3 wore TED hose.
-The medication aide (MA) did not tell her to apply TED hose to Resident #3.

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D 276	Continued From page 13 Interview with Resident #3 on 12/03/24 at 1:39 revealed: -She did not wear TED hose because the pair she had were loose on her legs. -Staff were supposed to order new TED hose a couple of months ago. -She did not know why the TED hose were never ordered. -When she had TED hose that fit, she put the TED hose on in the mornings and took them off in the evenings. -She did not allow staff to apply TED hose. -She did not have swelling in her feet and ankles. -The resident had a pair of size large TED hose in her top dresser drawer. Interview with a second shift PCA on 12/03/24 at 3:55pm revealed: -She did not know Resident #3 wore TED hose. -The MA was responsible for telling PCAs to TED hose to residents. -The MA did not tell her to TED hose to Resident #3. Interview with a first shift MA on 12/04/24 at 12:01pm revealed: -She was not aware Resident #3 wore TED hose. -Third shift MAs were responsible for applying TED hose and second shift MAs were responsible for removing TED hose. -The MA or Resident Care Coordinator (RCC) was responsible for measuring and ordering TED hose for residents. -The MA could not recall ordering TED hose for Resident #3. Telephone interview with a pharmacist with the facility's contracted pharmacy on 12/04/24 at 3:15pm revealed: -Resident #3 did not have an order for TED hose.	D 276		

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D 276	Continued From page 14 -The facility had not requested TED hose for Resident #3. -The pharmacy did not dispense Resident #3's TED hose. -The pharmacy did not enter the TED hose on Resident #3's eMAR. Interview with a second shift MA on 12/05/24 at 1:53pm revealed: -The MA was not aware Resident #3 wore TED hose. -The third shift MAs were responsible for ensuring TED hose were placed and the second shift MAs were responsible for ensuring TED hose are removed at night. Telephone interview with Resident #3's primary care provider (PCP) on 12/04/24 3:24pm revealed: -The TED hose were ordered for edema in the resident's legs. -The facility did not make her aware the resident was not wearing TED hose. -Resident #3 could have increased edema if TED hose were not worn as ordered. Interview with the RCC on 12/05/24 at 4:10pm revealed: -First shift MAs were responsible for ensuring TED hose were worn. -Second shift MAs were responsible for ensuring TED hose were removed at night. -The MAs were responsible for measuring and ordering TED hose for residents. -MAs were responsible for getting measurements for TED hose and faxing the measurements pharmacy. -MAs notified the PCP by documenting on the tracking form and placing a copy of them in the PCP's folder.	D 276		

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-The PCP checked the folder when she was in the facility.
-Resident #3 would have increased swelling in her legs if she was not wearing TED hose as ordered by the physician.

Interview with the Administrator on 12/05/24 at 4:55pm revealed:
-He was not aware Resident #3 was not wearing TED hose as ordered by the PCP.
-The PCP wrote orders and the MAs were responsible for reviewing the orders and faxing the orders to the pharmacy.
-It was the responsibility of the MA to order TED hose.
-MAs should use the tracking form to chart orders from the beginning to end.
-He expected MAs to follow the PCP's orders.
2. Review of Resident #4's current FL-2 dated 09/11/24 revealed:
-Diagnoses included hypertension, hyperlipidemia, rheumatoid arthritis, osteoarthritis, and osteoporosis.
-There was no order to apply TED hose.

Review of Resident #4's October 2024 electronic medication administration record (eMAR) revealed:
-There was no entry for TED hose to be applied to lower legs every morning and removed at bedtime.
-There was no documentation TED hose were applied from 10/01/24 to 10/31/24.

Review of Resident #4's November 2024 eMAR revealed:
-There was no entry for TED hose to be applied to lower legs every morning and removed at bedtime.
-There was no documentation TED hose were

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D 276	Continued From page 16 applied from 11/01/24 to 11/30/24. Review of Resident #3's December 2024 eMAR from 12/01/24-12/03/24 revealed: -There was no entry for TED hose to be applied to lower legs every morning and removed at bedtime. -There was no documentation TED hose were applied from 12/01/24 to 12/03/24. Observation of Resident #4 on 12/04/24 at 11:30am revealed she was wearing knee-high TED Hose bilaterally. Observation of Resident #4 on 12/05/24 at 2:30pm revealed she was wearing knee-high TED Hose bilaterally. Interview with Resident #4 on 12/04/24 at 11:30am revealed: -She wore TED hose most days, but not every day. -She applied the TED hose herself; she did not require assistance from the facility staff. -She did not know if the facility staff knew she wore TED hose. Telephone interview with Resident #4's Primary Care Provider (PCP) on 12/04/24 at 3:11pm revealed: -Resident #4 did not have an order for TED hose. -She did not know Resident #4 was wearing TED hose. -TED hose could cause a flare up of neuropathy due to the tightness of the TED hose. -Resident #4 had complained of pain in her lower legs. Interview with a medication aide (MA) on 12/05/24 at 12:57pm revealed:	D 276		

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D 276	Continued From page 17 -She did not know Resident #4 wore TED hose. -She had not seen an order for TED hose for Resident #4. -She did not document on Resident #4's eMAR because Resident #4 self-administered her medications so she would not know if Resident #4 had TED hose on her eMAR or not. Interview with another MA on 12/05/24 at 1:45pm revealed: -She did not know Resident #4 wore TED hose. -She had not seen an order for Resident #4 to wear TED hose. -She did not assist with placing Resident #4's TED hose on each morning. Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:09pm revealed: -She did not know Resident #4 wore TED hose. -Resident #4 did not have an order for TED hose. -Resident #4 was independent and self-administered her medications. -The nurse would assess Resident #4 quarterly or more often if needed to ensure her medications and orders were correct. Interview with the Administrator on 12/05/24 at 5:05pm revealed: -The facility staff should be aware of Resident #4 wearing TED hose. -If there was no order, the MAs should have obtained an order for the TED hose. -The nurse should have noticed Resident #4 wearing TED hose during her assessment.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 283		

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D 283	Continued From page 18 (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that the kitchenettes in each dining room were kept in a clean and orderly manner and free from contamination. The findings are: Observations of the kitchenettes on 12/03/24 from 4:00pm-4:20pm revealed: -There were 3 kitchenettes on each floor. -There were crumbs, dried substances, and debris on the inside of the refrigerators. -The outside of the refrigerators had dried liquid spills/splatters. -The inside of the microwaves had dried food splatters. -One of the microwaves had a food plate with breakfast food. -Multiple beverage pitchers were not covered or	D 283		

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labeled as to when prepared including grape juice, orange juice, tomato juice, and apple juice.
-A coffee cart had debris and dried spills on each of the three shelves.

Interview with a personal care aide (PCA) on 12/05/24 at 2:45pm revealed:
-The kitchenette was cleaned by PCAs from each shift.
-The PCAs cleaned the counters, washed dirty dishes and swept the floors.
-She did not know who was responsible for cleaning the refrigerator.
-She had not cleaned the refrigerator.
-She had not noticed any liquids or food uncovered in the refrigerator.

Interview with another PCA on 12/05/24 at 3:15pm revealed:
-The PCAs were responsible for cleaning the kitchenettes each shift.
-The PCAs wiped down the counters, swept the floor, and cleaned inside the microwave.
-She had not cleaned inside the refrigerator, but she had discarded outdated items.
-Beverages should be covered with a top or plastic wrap and dated.

Interview with a medication aide (MA) on 12/05/24 at 1:20pm revealed:
-The PCAs were responsible for cleaning the kitchenettes on each floor but if there was something dirty, she would wipe it down.
-Beverage pitchers should be covered.
-She had not seen any beverage pitchers that were not covered.
-She tried to keep the beverage pitchers covered when she worked.

Interview with a second shift MA on 12/05/24 at

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D 283	Continued From page 20 2:30pm revealed: -The PCAs were responsible for cleaning the kitchenettes. -She cleaned the kitchenette after she passed medications to residents, if she had time during the evenings. -Third shift PCAs were responsible for sweeping and mopping the floor in the kitchenettes. Interview with the Dietary Manager (DM) on 12/05/24 at 2:47pm revealed: -The 3rd shift care staff were responsible for breaking down the kitchenette and cleaning. -Beverages in the kitchenette refrigerators should be covered and dated. -If he saw beverages that were not dated or did not have a lid, he would dispose of the beverage because without a date he would not know when it was prepared. -He tried to make rounds in each dining room/kitchenette at the beginning of the week and again at the end of the week. Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:05pm revealed the PCAs and MAs were responsible for cleaning the kitchenettes after each meal. Interview with the Administrator on 12/05/24 at 4:59pm revealed: -Any food contact areas should be cleaned as used. -Equipment in the kitchenettes should be cleaned as needed or routinely. -All food, including beverages should be labeled and dated. -Ultimately the DM was responsible but the PCAs should make sure the beverages were labeled and covered.	D 283		

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D 344	Continued From page 21	D 344		
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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to clarify medication orders and physician orders for 1 of 5 sampled residents (#4) for a supplement and for daily blood pressure (BP) checks. The findings are: Review of Resident #1's current FL-2 dated 09/11/24 revealed diagnoses included hypertension, hyperlipidemia, rheumatoid arthritis, osteoarthritis, and osteoporosis. 1. Review of Resident #1's current FL-2 dated 09/11/24 revealed there was an order for vitamin B-12 (used as a supplement to elevate vitamin B-12) daily. Review of a signed physician's ordered dated 07/22/24 revealed:	D 344		

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-There was an order to discontinue vitamin B 12 daily.
-There was an order to administer vitamin B 12 weekly.

Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for vitamin B-12 1000mg weekly on Monday.
-There was documentation vitamin B-12 was administered on each 10/07/24, 10/14/24, 10/21/24, and 10/28/24.
-There was no entry for vitamin B-12 daily.
-There was no documentation vitamin B-12 was administered daily.

Review of Resident #1's November 2024 eMAR revealed:
-There was an entry for vitamin B-12 1000mg weekly on each Monday.
-There was documentation vitamin B-12 was administered on 11/04/24, 11/11/24, 11/18/24, and 11/25/24.
-There was no entry for vitamin B-12 daily.
-There was no documentation vitamin B-12 was administered daily.

Review of Resident #1's December 2024 eMAR from 12/01/24 to 12/02/24 revealed:
-There was an entry for vitamin B-12 1000mg weekly on each Monday.
-There was documentation vitamin B-12 was administered on 12/02/24.
-There was no entry for vitamin B-12 daily.
-There was no documentation vitamin B-12 was administered daily.

Observation of Resident #1's medication on hand 12/04/24 at 2:45pm revealed:

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-Resident #4 self-administered her medications.
-There was a bottle of vitamin B-12 1000mg available for administration in Resident #4's room.

Interview with Resident #1 on 12/04/24 at 11:30am revealed:
-The Primary Care Provider (PCP) discontinued the daily vitamin B12 in July 2024 because her B-12 level was elevated.
-The PCP ordered vitamin B12 1000mg weekly.
-The vitamin B 12 had not been changed back to daily administration.

Telephone interview with a representative at the facility's contracted pharmacy on 12/05/24 at 2:35pm revealed:
-The pharmacy had an order for vitamin B12 1000mg weekly.
-The order was profiled for the facility.
-The pharmacy did not dispense Resident #4 medications.

Interview with a medication aide (MA) on 12/05/24 at 12:57pm revealed:
-Resident #4 self-administered her medications.
-The MAs did not administer her medications and did not document on the eMAR.
-The eMAR was set up to automatically document since she self-administered her medications.
-She did not know if Resident #4's vitamin B12 was daily or weekly.

Telephone interview with Resident #4's PCP on 12/04/24 at 3:11pm revealed:
-Resident #4's vitamin B-12 was changed in June 2024 from daily to weekly because her B-12 level was elevated.
-No one from the facility contacted her to clarify if vitamin B-12 was to continue to be administered

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weekly or to return to daily.
-Resident #4 should continue to be administered vitamin B-12 1000mcg weekly.

Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:09pm revealed:
-She did not realize the vitamin B12 order on the FL-2 was different from the current order being administered.
-The order should have been clarified by the nurse or the pharmacy.

Refer to the telephone interview with Resident #4's PCP on 12/04/24 at 3:11pm.

Refer to the interview with the RCC on 12/05/24 at 4:09pm.

Refer to the interview with the Administrator on 12/05/24 at 5:05pm.

2. Review of Resident #4's current FL-2 dated 09/11/24 revealed there was an order for blood pressure checks daily and to notify the Primary Care Provider (PCP) with parameters greater than 160/100 or less than 90/60.

Review of Resident #4's October 2024 electronic medication administration record (eMAR) revealed:
-There was no entry to check Resident #4's BP daily and to notify the PCP with parameters greater than 160/100 or less than 90/60.
-There was no documentation Resident #4's BP was checked daily in October 2024.

Review of Resident #4's November 2024 eMAR revealed:
-There was no entry to check Resident #4's BP daily and to notify the PCP with parameters

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greater than 160/100 or less than 90/60.
-There was no documentation Resident #4's BP was checked daily in November 2024.

Review of Resident #4's December 2024 eMAR from 12/01/24 to 12/02/24 revealed:
-There was no entry to check Resident #4's BP daily and to notify the PCP with parameters greater than 160/100 or less than 90/60.
-There was no documentation Resident #4's BP was checked daily from 12/01/24 to 12/02/24.

Review of the vital sign sheet for October 2024 and November 2024 revealed Resident #4's BP was checked monthly.

Interview with Resident #4 on 12/04/24 at 11:30am revealed:
-She took medication for her blood pressure daily.
-The PCP stopped one of the blood pressure medications about 5 months ago because the medication was causing swelling in her feet and increased another blood pressure medication.
-Her blood pressure was checked by the Primary Care Provider (PCP) during the visit.
-The facility staff did not check her blood pressure.
-She had not had a problem with her blood pressure in the past 3 months.

Interview with a medication aide (MA) on 12/05/24 at 12:57pm revealed she did not take Resident #4's blood pressure.

Telephone interview with Resident #4's PCP on 12/04/24 at 3:11pm revealed:
-She obtained a blood pressure reading on Resident #4 with each visit.
-Resident #4's blood pressure was stable and had been for quite some time.

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-There was no reason for Resident #4's blood pressure to be checked daily.
-No one from the facility contacted her to clarify how frequently Resident #4's blood pressure should be checked.

Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:09pm revealed:
-She did not realize there was an order for daily blood pressure checks with parameters to notify the PCP.
-The order should have been clarified by the nurse or the pharmacy since Resident #4 did not have any problems with her blood pressure.

Refer to the telephone interview with Resident #4's PCP on 12/04/24 at 3:11pm.

Refer to the interview with the RCC on 12/05/24 at 4:09pm.

Refer to the interview with the Administrator on 12/05/24 at 5:05pm.

_____

Telephone interview with Resident #4's Primary Care Provider (PCP) on 12/04/24 at 3:11pm revealed:
-Resident #4's annual FL-2 was completed by the facility nurse.
-She expected the FL-2 to be correct when she received it from the FL-2 from the nurse for signature.

Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:09pm revealed:
-The nurse completed the annual FL-2s for each resident.
-She did not know where the nurse received the information that she placed on the annual FL-2s.
-She thought the nurse got the most recent

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D 344	Continued From page 27 eMAR. -The PCP signed the FL-2s once completed by the nurse. -The FL-2 should be faxed to the pharmacy if there were any changes. Interview with the Administrator on 12/05/24 at 5:05pm revealed: -The nurse completed the annual FL-2s for each resident and the PCP would sign the FL-2. -The FL-2 should have been completed by the information of the eMAR. -The FL-2 should have been faxed to the pharmacy after being signed by the PCP. -The facility staff should have made the changes in the eMAR as there were changes on the FL-2.	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 administer medications as ordered for of 3 of 5 sampled residents (#1, #2, and #4) who had a medication for pain (#1); a medication used to treat memory loss and confusion (#2); and a medication for allergies (#4).	D 358		

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D 358	Continued From page 28 The findings are: 1. Review of Resident #1's current FL-2 dated 10/29/24 revealed: -Diagnosis included diabetes mellitus type 2. -There was an order for diclofenac sodium gel 1% (a medicated gel used to treat pain) apply 2 grams to lower legs at night for pain. Review of Resident #1's signed physician's order dated 07/09/24 revealed there was an order for diclofenac sodium gel 1% apply 2 grams to lower legs at night for pain. Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed: -There was an entry for diclofenac sodium gel 1% apply 2 grams to both lower legs at bedtime for pain with a scheduled administration time of 8:00pm. -There was documentation diclofenac sodium gel was applied each night from 10/01/24 to 10/21/24, 10/23/24, and 10/25/24 to 10/31/24. -There was no documentation of 10/22/24 and 10/24/24; the eMAR was blank. Review of Resident #1's November 2024 eMAR revealed: -There was an entry for diclofenac sodium gel 1% apply 2 grams to both lower legs at bedtime for pain with a scheduled administration time of 8:00pm -There was documentation diclofenac sodium gel was applied each night from 11/01/24 to 11/30/24. Review of Resident #1's December 2024 eMAR from 12/01/24 to 12/02/24 revealed: -There was an entry for diclofenac sodium gel 1% apply 2 grams to both lower legs at bedtime for	D 358		

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pain with a scheduled administration time of 8:00pm.
-There was documentation diclofenac sodium gel was applied each night from 12/01/24 to 12/02/24.

Observation of Resident #1's medications on hand on 12/03/24 at 11:24am revealed there was no diclofenac sodium gel available to be administered.

Interview with Resident #1 on 12/05/24 at 2:35pm revealed:
-Her legs hurt most of the time.
-She had diclofenac gel for her leg pain.
-The diclofenac gel was not applied to her legs every night.
-She did not know why the diclofenac gel was not applied to her legs every night.
-Her family brought the brand name of diclofenac gel to the facility to be applied on her legs, but it was not being applied each night.

Telephone interview with a representative from the facility's contracted pharmacy on 12/03/24 at 1:19pm revealed:
-The pharmacy had an order for Resident #1 for diclofenac sodium gel 1% apply 2 grams to lower legs at night.
-The pharmacy dispensed a 100gm tube of diclofenac gel on 2/21/24, 07/12/24 and 12/03/24.
-Diclofenac gel 100gm tube would last 50 days.

Interview with a medication aide (MA) on 12/05/24 1:45pm revealed:
-Resident #1 did complain of pain in her lower legs.
-Resident #1 had a medicated gel to apply to her legs each night.
-She applied the medication to Resident #1's

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lower legs each evening when she worked.
-Resident #1 had diclofenac gel in her room that could be used.

Telephone interview with another MA on 12/05/24 at 2:08pm revealed:
-She applied medication to Resident #1's lower legs each night.
-Resident #1 did not like the generic medication gel so her family member brought her the brand name of medication gel.
-Resident #1 did not complain of leg pain.
-She used to complain of leg pain before her family brought in the name brand of the medication gel.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 12/04/24 at 3:11pm revealed:
-Diclofenac gel was a topical pain medication.
-Diclofenac gel should be applied to Resident #1's lower legs every night.
-If the medication was not applied to the lower legs nightly, and Resident #1 continued to have leg pain, she would not know how to accurately adjust Resident #1's medications.

Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:09pm revealed:
-The MAs should administer medications as ordered.
-Medication cart audits were completed monthly by the MA, the RCC, or the Nurse.
-The medication cart audit was to ensure all medications on the eMAR were in the medication cart and available for administration.
-There was no schedule to know who would complete the medication cart audit or what day of the month it was to be completed.

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Interview with the Administrator on 12/05/24 at 5:05pm revealed:
-The MAs should reorder medication when it got low.
-Resident #1 could have increased leg pain if the diclofenac gel was not applied as ordered.

Attempted telephone interview with Resident #1's family member on 12/03/24 at 2:09pm was unsuccessful.

2. Review of Resident #4's current FL-2 dated 09/11/24 revealed diagnoses included rheumatoid arthritis, osteoarthritis, hypertension, hyperlipidemia, and hypothyroidism.

Review of Resident #4's signed physician order dated 11/20/24 revealed there was an order for Allegra 180mg (used to treat symptoms of allergies) daily for 14 days.

Review of Resident #4's November 2024 electronic medication administration record (eMAR) from 11/22/24 to 11/30/24 revealed:
-There was an entry for Allegra 180mg daily with a scheduled administration time of 11:00am. May be self administered.
-There was documentation Allegra was administered daily from 11/22/24 to 11/30/24.

Review of Resident #4's December 2024 eMAR from 12/01/24 to 12/03/24 revealed:
-There was an entry for Allegra 180mg daily with a scheduled administration time of 11:00am. May be self administered.
-There was documentation Allegra was administered daily from 12/01/24 to 12/03/24.

Observation of Resident #4's medications on hand on 12/04/24 at 11:00am revealed there was

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D 358	Continued From page 32 no Allegra 180mg available to be administered. Interview with Resident #4 on 12/04/24 at 11:30am revealed: -The primary care provider (PCP) ordered Allegra because she was congested. -Allegra was ordered about the third week of November. -She received her monthly medications from a mail order pharmacy not the facility's contracted pharmacy. -The PCP sent the order to the facility's contracted pharmacy so she could get the medication quickly. -She never received Allegra from the facility's contracted pharmacy. -She did not know why she did not receive Allegra from the facility's contracted pharmacy. -She thought since the medication was over the counter the facility's contracted pharmacy may not have filled the prescription. Second interview with Resident #4 on 12/05/24 at 2:26pm revealed: -She asked the MAs if the Allegra had been delivered and she was told it had not been received. -She was not sure why the facility's contracted pharmacy did not dispense the medication. Telephone interview with a representative from the facility's contracted pharmacy on 12/05/24 at 2:33pm revealed: -Resident #4 had an order for Allegra 180mg daily for 14 days. -The pharmacy profiled the medication order so it would show up on Resident #4's orders. -The pharmacy did not dispense Allegra for Resident #4; she received her medications from another pharmacy.	D 358		

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D 358	Continued From page 33 Telephone interview with Resident #4's PCP on 12/04/24 at 3:11pm revealed: -She wrote the order for Allegra because Resident #4 had some congestion. -She left the prescription at the facility so the medication could be ordered through the facility's contracted pharmacy. -She discussed with Resident #4 which pharmacy she wanted to dispense the medication, and it was decided to use the facility's contracted pharmacy. -She did not know Resident #4 never received the Allegra that had been prescribed. Interview with a medication aide (MA) on 12/05/24 at 12:57pm revealed: -When the PCP wrote an order the prescription would be faxed to the facility's contracted pharmacy and the MA would enter the medication into the eMAR. -The third shift MA received the medications from the facility's contracted pharmacy. -If the medications was a self-administered medication, the third shift would take the medication to the resident's room or leave it for the first shift MA to take to the resident's room. -She did not recall Resident #4 complaining of congestion. -She did not remember if Resident #4 received Allegra from the facility's contracted pharmacy. Interview with a MA on 12/05/24 at 1:45pm revealed: -She worked third shift and received the medications from the facility's contracted pharmacy. -She did not recall receiving Allegra for Resident #4 from the facility's contracted pharmacy.	D 358		

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D 358	Continued From page 34 Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:09pm revealed: -The Allegra was not delivered to the facility from the facility's contracted pharmacy. -She was notified by the facility's contracted pharmacy that they did not dispense medications for Resident #4; Resident #4 received her medications from another pharmacy. -She told Resident #4 the Allegra would not be dispensed from the facility's contracted pharmacy. -She did not know who entered the Allegra order into the eMAR. -The eMAR automatically documents unassisted self-administration (U-SA) for all residents who self-administer their medications. -It would appear by looking at the eMAR that Resident #4 had taken Allegra. -The PCP was notified that the Allegra was never dispensed. -She did not document that she notified the PCP that the Allegra was not dispensed. Interview with the Administrator on 12/05/24 at 5:05pm revealed: -The facility does not coordinate medications for residents who self-administer medications. -It was not part of Resident #4's care plan to manage her medications. -The medication should not have been reflected on the eMAR if the residents did not receive the medication. 3. Review of Resident #2's current FL-2 dated 11/12/24 revealed: -Diagnoses included dementia, mild cognitive impairment, attention deficit hyperactivity disorder, depression, and anxiety. -There was an order for Donepezil 10mg at bedtime.	D 358		

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D 358	Continued From page 35 -There was an order for Donepezil 5mg at bedtime. Review of Resident #2's signed physician's order dated 03/20/24 revealed an order for Donepezil 5mg at bedtime for 4 weeks, then 10mg thereafter. Review of Resident #2's signed physician's order dated 11/04/24 revealed an order for Donepezil 5mg at bedtime for 4 weeks, then 10mg thereafter. Review of Resident #2's March 2024-May 2024 electronic medication administration record (eMAR) revealed: -There was no entry for Donepezil 5mg or Donepezil 10mg at bedtime. -There was no documentation Donepezil was administered. Review of Resident #2's October 2024 eMAR revealed: -There was no entry for Donepezil 5mg or Donepezil 10mg at bedtime. -There was no documentation Donepezil was administered. Review of Resident #2's November 2024 eMAR revealed: -There was an entry for Donepezil 5mg with a scheduled administration time of 8:00pm. -There was documentation that Donepezil 5mg was administered from 11/05/24-11/27/24. -There was documentation that Donepezil 5mg was not administered by the facility staff on 11/28/24-11/30/24 with the exception documented as the resident was away from the facility with medications.	D 358		

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Review of Resident #2's December 2024 eMAR from 12/01/24-12/03/24 revealed:
-There was an entry for Donepezil 5mg with a scheduled administration time of 8:00pm.
-There was documentation that Donepezil 5mg was administered from 12/01/24-12/02/24.

Observation of Resident #2's medications on hand on 12/03/24 at 11:57am revealed:
-There was a punch card with 30 tablets of Donepezil 5mg dispensed on 11/05/24, with the directions to take one tablet at bedtime every night for 30 days.
-There were 16 of 30 tablets remaining on the punch card.

Telephone interview with a representative from the facility's contracted pharmacy on 12/03/24 at 2:17pm revealed:
-A prescription was received on 03/20/24 for Donepezil 5mg for Resident #2.
-The order was to administer Donepezil 5mg for 4 weeks and then increase to 10mg thereafter.
-Resident #2's Donepezil 5mg was dispensed on 03/22/24 for 28 tablets.
-Resident #2's Donepezil 10mg was not dispensed because it was not requested to be filled.
-Resident #2's medication was not automatically dispensed and had to be requested.
-Donepezil was used to diminish the effects of dementia, to prolong good days.

Based on observations, record reviews, and interviews Resident #2's Donepezil 5mg was not documented as administered from 03/22/24 for 4 weeks and was not titrated up to Donepezil 10mg. On 11/05/24, thirty tablets of Donepezil 5mg were dispensed and there were 16 of 30 tablets remaining in the packet; 22 tablets were

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D 358	Continued From page 37 documented as administered. Telephone interview with Resident #2's geriatric practitioner's nurse on 12/03/24 at 3:13pm revealed: -Resident #2's current medication profile had Donepezil 10mg documented as the current dosage. -On 03/20/24, Donepezil 5mg was ordered for 4 weeks and then the dosage was to increase to Donepezil 10mg ongoing. -On 05/07/24, Resident #2's current medication profile showed Donepezil 10mg as the current dosage. -There was no documentation that the geriatric practitioner was notified Resident #2 had not received the Donepezil 10mg. -Resident #2 should have been administered Donepezil 5mg for 4 weeks beginning 03/20/24 and then Donepezil 10mg until current. Telephone interview with a second MA on 12/05/24 at 2:21pm revealed she did not recall anything about Resident #2's Donepezil dosage changing and the medication not being administered. Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:05pm revealed: -New orders were faxed to the pharmacy by whoever received the order. -All new orders were tracked on the facility's new order tracking form. -The MAs entered the orders into the eMAR. -When a resident went to an outside provider, the resident was asked by the MAs for an after-visit summary. -She did not recall Resident #4 having an order for Donepezil 5mg for four weeks and then the medication was to be increased to 10mg daily.	D 358		

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D 358	Continued From page 38 -Usually when the 4-weeks were up the pharmacy would automatically send the next dosage, so it would be available to be administered. -Her concern was the order was not followed and Resident #2 did not receive her medication as ordered. Interview with the Administrator on 12/05/24 at 4:59pm revealed he was concerned Resident #2's Donepezil had not been administered as ordered. Attempted telephone interview with Resident #2's primary care provider (PCP) on 12/05/24 at 1:17pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #2 was a poor historian.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure staff documented on the electronic medication administration record (eMAR) immediately	D 366		

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following administration of medication for 2 of 5 sampled residents (#1 and #2) including a medication for diarrhea (#1) and a pain medication (#2).

1. Review of Resident #2's current FL-2 dated 11/12/24 revealed:
-Diagnoses included dementia, mild cognitive impairment, attention deficit hyperactivity disorder, depression, and anxiety.
-There was an order for Acetaminophen (used to treat mild pain) 500mg, take two tablets every six hours as needed (PRN) for pain.

Review of Resident #2's October 2024 electronic medication administration record (eMAR) from 10/25/24-10/31/24 revealed:
-There was an entry for Acetaminophen 500mg take two tablets every six hours PRN pain.
-There was no documentation that Acetaminophen 500mg was administered from 10/25/24-10/31/24.

Review of Resident #2's November 2024 eMAR revealed:
-There was an entry for Acetaminophen 500mg take two tablets every six hours PRN pain.
-There was documentation that Acetaminophen 500mg was administered on 11/12/24.
-There was no other documentation Acetaminophen 500mg was administered.

Review of Resident #2's December 2024 eMAR from 12/01/24-12/02/24 revealed:
-There was an entry for Acetaminophen 500mg take two tablets every six hours PRN pain.
-There was no documentation that Acetaminophen 500mg was administered from 12/01/24-12/03/24.

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BROOKDALE CHAPEL HILL AL (NC)	2220 FARMINGTON DRIVE CHAPEL HILL, NC 27514

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Observation of Resident #2's medications on hand on 12/03/24 at 11:57am revealed:
-There was a bubble pack of Acetaminophen 500mg with the directions to take two tablets equal to 1000mg four times a day as needed for pain. "Maximum dose of Acetaminophen from all sources 4000mg/day."
-The bubble pack was dispensed on 10/25/24 for 60 tablets of Acetaminophen with two tablets per bubble to equal 30 doses.
-There were 3 doses remaining on the bubble pack; 27 doses had been punched.

Based on record reviews, interviews, and observation of medication on hand it was determined that 30 doses of Acetaminophen 500mg (1000mg) tablets were dispensed on 10/25/24 with 3 doses remaining, 1 dose was documented as administered and no other documentation of administration leaving 26 doses unaccounted for.

Telephone interview with the facility's contracted primary care provider (PCP) on 12/04/24 at 3:26pm revealed:
-Resident #2's liver function was elevated, and she had to wean the resident off Acetaminophen.
-Resident #2 complained of chronic pain, so it would be concerning not knowing how often the resident was taking Acetaminophen.

Telephone interview with a medication aide (MA) on 12/05/24 at 1:34pm revealed:
-If a resident requested a PRN medication, she would check to see the last time the medication had been administered and how often the medication could be administered before she administered the medication to ensure the resident did not receive too much of the medication.

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-She documented when she administered Resident #2's Acetaminophen.
-She did not recall the last time she administered Resident #2's Acetaminophen.

Telephone interview with a second MA on 12/05/24 at 2:21pm revealed:
-She had administered Acetaminophen to Resident #2; it was about a month and a half ago.
-She did not know why Resident #2's Acetaminophen had doses punched from the card but were not documented.
-Medication that was administered PRN, should be documented.
-The MAs had to document the reason the medication was administered and the effectiveness of the medication.

Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:05pm revealed:
-If Resident #2 was administered Acetaminophen and it was not documented the resident could be getting too much.
-When Resident #2's Acetaminophen was administered it also needed to be documented so the PCP would know how often the resident was taking the medication.
-When PRN medication was administered, the administration should be documented on the residents' eMAR.
-The reason why the PRN medication was administered, and the effectiveness of the medication should be documented.
-Documenting PRN medication was important because the MA would not know another MA had already administered the medication if it was not documented.

Interview with the Administrator on 12/05/24 at 4:59pm revealed:

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-Medication that was to be administered PRN, should be documented when the medication was administered.
-He was concerned Resident #2 had medications that were missing and were not documented.
-If the medication was not documented, you would not know if the medication had been administered as prescribed.

2. Review of Resident #1's current FL-2 dated 10/29/24 revealed:
-Diagnoses included diabetes mellitus type 2 and major depression.
-There was an order for Imodium A-D (used to treat occasional diarrhea) 2 tablets every 24 hours as needed for diarrhea, then 1 tablet for each loose stool.

Review of Resident #1's October 2024 electronic medication administration record (eMAR) from 10/07/24 to 10/31/24 revealed:
-There was an order for Imodium A-D 2 tablets every 24 hours as needed for diarrhea, then 1 tablet for each loose stool.
-There was no documentation Imodium A-D was administered from 10/07/24 to 10/31/24.

Review of Resident #1's November 2024 eMAR revealed:
-There was an order for Imodium A-D 2 tablets every 24 hours as needed for diarrhea, then 1 tablet for each loose stool.
-There was no documentation Imodium A-D was administered from 11/01/24 to 11/30/24.

Review of Resident #1's December 2024 eMAR from 12/01/24 to 12/02/24 revealed:
-There was an order for Imodium A-D 2 tablets every 24 hours as needed for diarrhea, then 1 tablet for each loose stool.

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-There was no documentation Imodium A-D was administered from 12/01/24 and 12/02/24.

Observation of Resident #1's medications on hand on 12/03/24 at 11:57am revealed:
-There was a ziploc bag with a prescription label attached that read Imodium A-D 2 tablets every 24 hours as needed for diarrhea, then 1 tablet for each loose stool.
-The pharmacy dispensed 30 Imodium A-D tablets on 10/07/24.
-There were 24 of 30 tablets remaining, leaving 6 tablets unaccounted for.

Telephone interview with a representative from the facility's contracted pharmacy on 12/05/24 at 2:33pm revealed:
-Resident #1 had an order dated 10/07/24 for Imodium A-D 2 tablets every 24 hours as needed for diarrhea, then 1 tablet for each loose stool.
-The pharmacy dispensed 30 Imodium A-D tablets on 10/07/24.

Interview with Resident #1 on 12/04/24 at 8:13am revealed:
-She had diarrhea sometimes; maybe 3 times a month.
-The medication aide (MA) would give her medication for diarrhea when she asked for the medication.
-She did not know the last time she had diarrhea or when she took medication for diarrhea.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 12/04/24 at 3:11pm revealed:
-Resident #1 had a problem with diarrhea a few months ago, but she had not been notified of any problem recently.
-Resident #1 had an order for Imodium A-D when

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needed for episodes of diarrhea.
-She did not know how often Resident #1 took Imodium A-D.

Interview with a MA on 12/05/24 at 12:57pm revealed:
-Resident #1 complained of diarrhea 1 to 2 times a month.
-Resident #1 had an order for Imodium A-D as needed for diarrhea.
-She had administered Imodium A-D to Resident #1, but could not remember the date.
-She forgot to enter the administration of the Imodium A-D on the eMAR.
-She put it on the 24-hour shift report to inform the on-coming MA.
-She should have documented the administration of the Imodium A-D on the eMAR.

Telephone interview with another MA on 12/05/24 at 1:45pm revealed:
-Resident #1 had flare-ups of diarrhea.
-Resident #1 had a flare-up about two weeks ago.
-Resident #1 had an order for Imodium A-D as needed for diarrhea but she did not administer the Imodium A-D a few weeks ago because Resident #1 only had 1 episode of diarrhea.

Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:09pm revealed:
-The MAs should chart on the eMAR each time an as needed medication was administered.
-Resident #1 could be administered the medication to close together.
-The MAs would not know the residents had received the as needed medication.

Interview with the Administrator on 12/05/24 at 5:05pm revealed:
-The MAs should document all as needed

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D 366	Continued From page 45 medications on the eMAR. -The eMAR should be accurate of all medications administered. -The on-coming MA would not know the correct time for the next as needed dose of medication.	D 366		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 2 sampled residents (#2) had a physician order to self-administer medications related to a medication for mild pain, an inhaler, and an allergy medication (#2). The findings are: Review of the facility's self-administration medication policy dated as last revised August 2023 revealed:	D 375		

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-If a resident desired to self-administer medications, an evaluation should be conducted by the nurse, of the resident's cognitive, physical, and visual ability to carry this out.
-The resident's ability to self-administer medications, including over the counter medications should be determined by means of a skills evaluation as follows. The resident should be able to identify the medication state what the purpose was for the medication, what time the medication was to be taken, the proper dosage and route of the medication, identify the expiration date of the medication, verbalize the steps involved in medication administration and properly store medications.
-If the resident successfully passed the self-medication evaluation an order should be attained from the position and should be reflected on the physician plan of care.

Review of Resident #2's current FL-2 dated 11/12/24 revealed:
-Diagnoses included dementia, mild cognitive impairment, attention deficit hyperactivity disorder, depression, and anxiety.
-She was intermittently disoriented.

Review of Resident #2's care plan dated 11/18/24 revealed Resident #2 needed assistance with medication management.

Review of Resident #2's primary care provider (PCP) after-visit summary dated 10/29/24 revealed:
-Resident #2 had moderate vascular dementia.
-No wandering or exit-seeking behaviors had been reported.
The plan was to continue to reside in an assisted living facility.
-Staff to provide a safe and secure environment.

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D 375	Continued From page 47 Observation of Resident #2's room on 12/03/24 at 8:52am revealed: -There was a box of 24 over-the-counter (OTC) Benadryl (used to treat allergies) on the table beside her chair. -There was an Albuterol inhaler in a plastic bag on the seat of her recliner chair; there were 176 of 200 inhalations remaining in the inhaler. Interview with Resident #2 on 12/03/24 at 8:53am revealed: -"My memory is really bad." -She did not know how often she used Benadryl or the Albuterol inhaler. -She began to mumble and was difficult to understand. Observation of Resident #2's room on 12/04/24 at 10:07am revealed: -The box of Benadryl had been moved to the countertop by the sink. -There were 5 tablets remaining in the box. -The box was labeled with an expiration date of 06/2021. -There was a bottle of Acetaminophen 500mg on the bedside table. -The bottle contained three different types of tablets, all of which were Acetaminophen 500mg. -There were more than 15 tablets in the bottle. -The inhaler had been moved to her bedside table; the expiration date was 09/2022. Interview with Resident #2 on 12/04/24 at 10:09am revealed: -She took one tablet of Benadryl, not every day, but it depended on what was going on: she could not explain what this meant. -Sometimes the facility staff gave her Acetaminophen and sometimes she took it from	D 375		

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her bottle.
-She used her inhaler when she could not catch her breath.
-She did not know how often she used the inhaler.
-When asked if she had any other medications in her room, she held up the control to her bed and said here is something.

Telephone interview with a representative from the facility's contracted pharmacy on 12/03/24 at 2:17pm revealed he did not see a self-administration order for Resident #2.

Telephone interview with the facility's contracted PCP on 12/04/24 at 3:26pm revealed:
-Resident #2's cognition had declined a lot.
-Resident #2 was super forgetful.
-Resident #2 could not self-administer her medication.
-Resident #2 should not have Acetaminophen and Benadryl in her room.
-If Resident #2 took too much Benadryl, the resident could have increased sedation which could increase the risk of falls and increased confusion.
-Resident #2's liver function was elevated, and she had to wean the resident off Acetaminophen.
-Resident #2 complained of chronic pain, so it would be concerning not knowing how often the resident was taking Acetaminophen.

Telephone interview with a medication aide (MA) on 12/05/24 at 1:34pm revealed:
-Resident #2 was forgetful.
-She had not seen medications in Resident #2's room.
-The concern would be the resident may take medications and overdose by taking too many or take medication when it was not needed.

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D 375	Continued From page 49 Telephone interview with a second MA on 12/05/24 at 2:21pm revealed: -Resident #2 should not have medications in her room. -She had not seen medications in Resident #2's room. -She would be concerned Resident #2 had medications in her room because Resident #2 had cognitive issues and could take the medication for not remember taking the medication. Telephone interview with Resident #2's family member on 12/05/24 at 3:44pm revealed: -Resident #2 had "early" Alzheimer's. -Resident #2 did not do her medications, the staff at the facility administered the resident's medications. -She should not have left the Benadryl in Resident #2's room. -Resident #2 had Acetaminophen to take as needed because sometimes staff were not available when the resident needed Acetaminophen. -It was possible Resident #2 could take Acetaminophen even though the facility staff had administered the medication. -Resident #2 had the inhaler to be used as needed. Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:05pm revealed: -Resident #2's memory was "all over the place." -One-minute Resident #2 was coherent and the next she might be babbling. -Resident #2 could not self-administer her medications. -Resident #2 would not know what her medications were or when to take the medication.	D 375		

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D 375	Continued From page 50 -She did not know Resident #2 had medications in her room. -Resident #2 should not have medications in her room because she did not have an order to self-administer medications. -Resident #2 should not take medications the staff did not know about. Interview with the Administrator on 12/05/24 at 4:59pm revealed: -He did not think Resident #2 could self-administer her medications. -Resident #2 received a diagnosis of dementia last month. -Resident #2 did not self-administer her medications and should not have medications in her room.	D 375		
D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that the residents' medications were stored safely and securely for 1 of 2 sampled residents who self-administered medication (#6). The findings are: Review of the facility's self-administration medication storage policy dated as last revised October 2018 revealed:	D 377		

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-Locking the resident's apartment door was considered the first level for securing medications in the resident's apartment.
-Residents who self-administer their own medications store and secure their non-controlled medication in their apartment by locking the apartment door each time upon departure.
-The resident should store their control medications in a locked drawer or cabinet, so the controlled medication was not accessible to others.
-Control medications were considered double locked when locked in a drawer or cabinet and when the apartment door was locked.

Review of Resident #6's current FL-2 dated 09/11/24 revealed:
-Diagnoses included essential hypertension, major depressive disorder, anxiety disorder, mild cognitive impairment, carpal tunnel syndrome, malignant neoplasm of prostate, and osteoarthritis.
-There was an order for Tramadol-Acetaminophen (used to treat moderate pain) 37.5-325 take two tablets every 4 hours as needed.
-There was an order for Flomax (used to treat an enlarged prostate) 0.4mg once daily.
-There was an order for Amlodipine(used to treat high blood pressure) 5mg once daily.
-There was an order for Cozaar (used to treat high blood pressure) 100mg once daily.
-There was an order for Acetaminophen (used to treat mild pain) 500mg two tablets every 8 hours as needed.
-There was an order for Zofran (used to treat nausea) 4mg every 6 hours as needed.
-There was an order for Pantoprazole (used to treat gastroesophageal reflux) 40mg once daily.
-There was an order for Gabapentin (used to

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treat pain) 100mg, three capsules, three times daily.
-There was an order for Finasteride (used to treat an enlarged prostate) 5mg once daily.
-There was an order for Atorvastatin Calcium (used to treat high cholesterol)10mg once daily.
-There was an order for Donepezil (used to treat Alzheimer's disease)10mg once daily.

Review of Resident #6's self-administration of medications quarterly review form dated 09/11/24 revealed:
-Print a list of current medications from the electronic medication administration record (eMAR) to use when evaluating the resident's ability to self-administer medications.
-The resident must be able to demonstrate basic competency in each applicable step before receiving initial or continuing approval for self-administration of any medications.
-The resident was to demonstrate secure storage for non-controlled medication by locking their door upon departure; fully capable was documented.

Interview with a resident on the 2nd floor on 12/04/24 at 12:24pm revealed:
-There were residents who were confused and went into other resident rooms.
-She locked her door because of the residents who might wander in.
-She had not had any residents go into her room, but she was being precautionary.

Observation of Resident #6's room on 12/04/24 at 12:34pm revealed the resident's room was not locked and multiple medications could be seen from the doorway including over-the-counter bottles on a table by the door, prescription bottles on top of a dresser, pain patches lying on the

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(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 377	Continued From page 53 table under the television as well as prescription bottles. Observation of Resident #6's medication in various visible locations in his room on 12/04/24 at 4:39 revealed: -There were multiple bottles of Acetaminophen 500mg. -There was a prescription bottle of Pregabalin (used to treat nerve pain) 25mg. -There were multiple Lidocaine 5% pain patches. -There was a prescription bottle of Myrbetriq(used to treat an overactive bladder) 25mg. -There was a bottle of Gabapentin 100mg. -There was a bottle of Duloxetine (used to treat depression) 20mg. -There was an OTC bottle of Vitamin B12 (supplement) 1000mcg. -There was an OTC bottle of Vitamin D3 (supplement). -There was an OTC bottle of multivitamins. -There was a prescription bottle of Tramadol-Acetaminophen 37.5-325. -There was a prescription bottle of Zofran 4mg. Observation of Resident #6's medication cabinet in his bathroom on 12/04/24 at 4:33pm revealed: -The cabinet was not locked. -There was a bottle of Amlodipine 5mg, Atorvastatin Calcium 10mg, Cozaar 100mg, Donepezil 10mg, Flomax 0.4mg, Finasteride 5mg, and Pantoprazole 40mg. Interview with Resident #6 on 12/04/24 at 4:39pm revealed: -He self-administered his medications. -He did not recall how his medications should be stored. -He did not generally lock his door.	D 377		

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	HAL032016	A. BUILDING: _____ B. WING _____	12/05/2024

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D 377	Continued From page 54 Interview with a medication aide (MA) on 12/05/24 at 1:20pm revealed: -She "usually" did not go into a resident's room who self-administered their medication. -Medication self-administered by the resident should be stored in a locked box. -There was a [named] resident on the 2nd floor who went into other resident rooms. -Other staff members usually let her know when medication was "sitting out" in a resident's room. -No one had reported to her that Resident #6 had medications that were not locked. -The concern with medications not being locked, was another resident could go into the room and "mess" with the medications. Telephone interview with a second MA on 12/05/24 at 2:21pm revealed: -She had been into Resident #6's room to take his blood pressure or to answer a call bell but the resident seldom needed anything. -It had been a long time since she had been into Resident #6's room. -Resident #6 self-administered his medications. -Resident #6's medications should be locked up, it was protocol. -There was a [named] resident who went into other residents' rooms, but she had not seen the resident near Resident #6's room. Interview with the Administrator on 12/05/24 at 4:59pm revealed: -If a resident self-administered medication, the resident should lock the door each time the resident left the room; it was the facility's policy. -It would be a safety concern if medications were not locked. -Medications should be locked to ensure the medications did not go missing.	D 377		

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D 448	Continued From page 55	D 448		
D 448	10A NCAC 13F .1211 Written Policies And Procedures 10A NCAC 13F .1211Written Policies And Procedures (a) An adult care home shall develop written policies and procedures that comply with applicable rules of this Subchapter, on the following: (1) ordering, receiving, storage, discontinuation, disposition, administration, including self-administration, and monitoring the resident's reaction to medications, as developed in consultation with a licensed health professional who is authorized to dispense or administer medications; (2) use of alternatives to physical restraints and the care of residents who are physically restrained, as developed in consultation with a registered nurse; (3) accident, fire safety and emergency procedures; (4) infection control; (5) refunds; (6) missing resident; (7) identification and supervision of wandering residents; (8) management of physical aggression or assault by a resident; (9) handling of resident grievances; (10)visitation in the facility by guests; and (11)smoking and alcohol use. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 448		

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D 448	Continued From page 56	D 448		

reviews, the facility failed to implement procedures to ensure medications were administered in accordance with physicians' orders for 1 of 1 sampled resident (#4) who self-administered medications.

The findings are:

Review of the facility's self-administration policy dated 08/2023 revealed the nurse should print a list of current medications from the order summary report or eMAR to use when evaluating the resident's ability to self-administer medications.

Review of Resident #4's current FL-2 dated 09/11/24 revealed diagnoses included hypertension, hyperlipidemia, rheumatoid arthritis, osteoarthritis, and osteoporosis.

Review of Resident #4's Resident Registry revealed there was an admission date of 05/02/18.

Observation of Resident #4's room on 12/04/24 at 11:30am revealed there was a bottle of leflunomide (used to treat rheumatoid arthritis) with a dispensed date of 11/01/24.

Review of Resident #4's self-administration assessment dated 11/20/24 revealed:
-The assessment was completed by the Health and Wellness Coordinator (HWC) on 11/20/24.
-Instructions were to print a list of current medications from the order summary report or the eMAR to use when evaluating the resident's ability to self-administer medications.
-The self-administration assessment was to be completed quarterly.
-Had there been a change in medications since

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D 448	Continued From page 57	D 448		

the last self-administration of medication review; the assessor marked "yes".
-The assessor verified medication profile was complete in the computer system; the assessor marked "yes".

Review of Resident #4's November 2024 electronic medication administration record (eMAR) revealed:
-There was no entry for leflunomide to be self-administered.
-There was no documentation Resident #4 self-administered leflunomide.

Review of Resident #4's December 2024 eMAR from 12/01/24 to 12/03/24 revealed:
-There was no entry for leflunomide to be self-administered.
-There was no documentation Resident #4 self-administered leflunomide.

Interview with Resident #4 on 12/04/24 at 11:30am revealed:
-She had self-administered her medications since she was admitted to the facility.
-A nurse would come into her room and go through her medications several times a year.
-She did not recall a nurse coming into her room in the past three months to go over her medications.

Telephone interview with a representative from Resident #4's Rheumatologist on 12/05/24 at 10:42am revealed:
-Resident #4 was seen in the office on 10/29/24.
-She was ordered a new medication, leflunomide, for her arthritis.
-She should be given an after-visit summary with each visit to take with her to the assisted living facility.

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D 448	Continued From page 58 Interview with a medication aide (MA) on 12/05/24 at 12:57pm revealed: -She did not do anything with the medications of a resident who self-administered medications. -If the facility's contracted PCP wrote an order the facility would know about the new order and enter the order into the eMAR. -If an outside physician wrote an order the facility staff would not know about the order unless the resident brought an order to the facility when they returned. -She did not know Resident #4 had started a new medication that the facility was unaware of. -She did not know if Resident #4 brought an after-visit summary back to the facility when she returned from a physicians appointment. Interview with Resident #4 on 12/05/24 at 2:26pm revealed: -The Rheumatologist ordered a new medication for arthritic pain on 10/29/24. -The physician's office faxed the prescription to the mail order pharmacy she used. -The medication was delivered in the mail, and she had been self-administering the medications. -She did not know if the facility staff was aware that she took a new medication for her arthritic pain or not; she had not told them. -She was given an after-visit summary of her Rheumatologist appointment on 10/29/24. -She did not give the after-visit summary to the facility staff; she did not know the facility staff needed the after-visit summary. -No one had asked to see the after-visit summary from her appointment on 10/29/24. Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 4:09pm revealed: The MAs should ask Resident #4 for the	D 448		

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after-visit summary when she returns from a physician's appointment.
-The MAs may have not known Resident #4 went to a physician's appointment.
-The nurse was responsible for reviewing Resident #4's medication with a current medication list.
-She did not know if the nurse took a current medication list when she reviewed self-administered medications.
-The facility should be aware of all medication's resident were taking and they should be entered into the eMAR whether the resident self-administered their medications or not.

Interview with the Administrator on 12/05/24 at 5:05pm revealed:
-The nurse was responsible for completing the self-administration assessment.
-The nurse should take a copy of the order summary and eMAR to compare with the medications in the room.
-The medications in the resident's room should be the same as the medications on the order summary.
-When a resident goes to a physician's appointment the facility staff should send a blank encounter form with the resident so the physician could document any changes made.